MAY 27 1930

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MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

11614

File No. .....

Registered No. 6

1. PLACE OF DEATH

County Lawrence — Registration District No. 35

Township Pleasant Ridge — Primary Registration District No. 5043

City ..... (No. ....., ... St. ..... Ward)

2. FULL NAME William Fancy Bateset

(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode). (If nonresident, give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	Wh	Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Lissie Bateset

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 11 1853

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	76	11	13	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN) Lawrence Co
(STATE OR COUNTRY) Mo

PARENTS

10. NAME OF FATHER — Bateset

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Malinda Browning

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY)

14. INFORMANT E. U. Bateset
(Address) Verona Mo

15. FILED 4/11, 1930 Mae J. Eggermeier REGISTRAR

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MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 25 1930

17. I HEREBY CERTIFY, That I attended deceased from Oct, 1929, to Apr 25, 1930 that I last saw him alive on Apr 22, 1930, and that death occurred, on the date stated above, at 6.45 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Uremia, Hyperthophy of Prostate, Hydro nephosis
936
137
1328 (duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Hypertension, ch Myocarditis (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED —
IF NOT AT PLACE OF DEATH .....
DID AN OPERATION PRECEDE DEATH? No DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) R A Cowan, M. D.
, 19 (Address) Aurora, Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Springriver Cemetery — DATE OF BURIAL April 26 1930

20. UNDERTAKER Wilks. — ADDRESS Verona Mo

NOTE—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.