

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

Do not use this space.

16836

1. PLACE OF DEATH

County Madison Registration District No. 274
Township Lewis Primary Registration District No. 6261
City (No. _____) St. _____ Ward _____

2. FULL NAME

Will Batchlor
(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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 8-10-1874

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
55 9 21

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Day Labour
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Bloomfield Mo.
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Tom Batchlor

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

12. MAIDEN NAME OF MOTHER Batchlor

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

14. INFORMANT Oscar Batchlor
(Address) Lilbourn Mo

15. FILED June 11 1931 E. F. Jones
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 31 1930

17. I HEREBY CERTIFY, That I attended deceased from 9 May 14, 1930, to May 16, 1930 that I last saw him alive on May 16, 1930 and that death occurred, on the date stated above, at 1140 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Tuberculosis

23A (duration) 2 yrs. 0 mos. 0 ds.

CONTRIBUTORY (SECONDARY) 31 (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) E. F. Jones M. D.

June 1, 1930 (Address) Lilbourn, 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 Kewanee Cem DATE OF BURIAL 6/1 1930

20. UNDERTAKER L. M. Bell ADDRESS Lilbourn Mo

N. B.—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.

