

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

33680  
Do not use this space.

OCT 20 1939

1. PLACE OF DEATH

(a) County Stoddard Registration District No. 837  
 (b) Township Caster Primary Registration District No. 4508  
 (c) City Bloomfield (d) Street No. \_\_\_\_\_ St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 324 Florah Della Batchelor

(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-13-1939

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

22. I HEREBY CERTIFY, That I attended deceased from Sept 12, 1939, to Sept 13, 1939

I last saw h. or alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at 1:55 a.m.

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 11-22-1876

The principal cause of death and related causes of importance were as follows:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
62 9 21

Cerebral Hemorrhage Date of onset Sept 1939

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife  
 9. Industry or business in which work was done, as saw mill, bank, etc. \_\_\_\_\_  
 10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

Other contributory causes of importance:  
Hypertension 1928

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo. O

FATHER 13. NAME Benj. Palmer I

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ill. E

MOTHER 15. MAIDEN NAME Margaret Christian

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

17. INFORMANT (ADDRESS) Love Henderson  
Bloomfield, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Lick Creek Cem. DATE Sept 14, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Chiles Und. Co.  
Bloomfield, Mo.

20. FILED Sept 18, 1939 Sophie Punch  
Local Registrar.

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
 If so, specify \_\_\_\_\_ (Signed) Dr. J. H. Garner  
Bloomfield, Mo.

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

103  
7  
D

15

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

Ivan Cooper....., Registered Apprentice No. 162  
working under my personal supervision.

Signed Lulu Cooper.....

Licensed Embalmer No. 3499

P. O. Address Bloomfield, Mo.

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**