No. 2
1-10-39
-17-39
X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 13929

Registration District No. 399   Primary Registration District No. 1002   Registrar's No. 1641

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 105 South Lawn
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ____ In this community ____ (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limit- write "RURAL")
(d) Street No. 105 South Lawn
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 54 years years.

3. (a) PRINT FULL NAME AMBROSE BATLINER 345

3. (b) If veteran, name war None   3. (c) Social Security No. No

4. Sex Male   5. Color or race White   6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Leontine Batliner   6. (c) Age of husband or wife if alive 70 years

7. Birth date of deceased April 28, 1867 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	72	11	17	____ hr. ____ min.

9. Birthplace ____ (City, town, or county) Litchenstein (State or foreign country)

10. Usual occupation Retired 7

11. Industry or business W. S. Dickey Clay Co. 7

FATHER
12. Name Martin Batliner 7
13. Birthplace Litchenstein
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Katherine Mott
15. Birthplace Litchenstein
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Leontine Batliner
(b) Address 105 So. Lawn

17. (a) Burial (Burial, cremation, or removal)   (b) Date thereof 4/18/40 (Month) (Day) (Year)
(c) Place: burial or cremation St. Mary's Cem   31

18. (a) Signature of funeral director Zwick & Sohn Co
(b) Address K. C. Mo

19. (a) April 17, 1940 (Date received local registrar)   M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 15 year 1940 hour 5 P minute 58 P. M.

21. I hereby certify that I attended the deceased from Dec. 14, 1939, to April 15, 1940, that I last saw him alive on April 15, 1940 and that death occurred on the date and hour stated above.

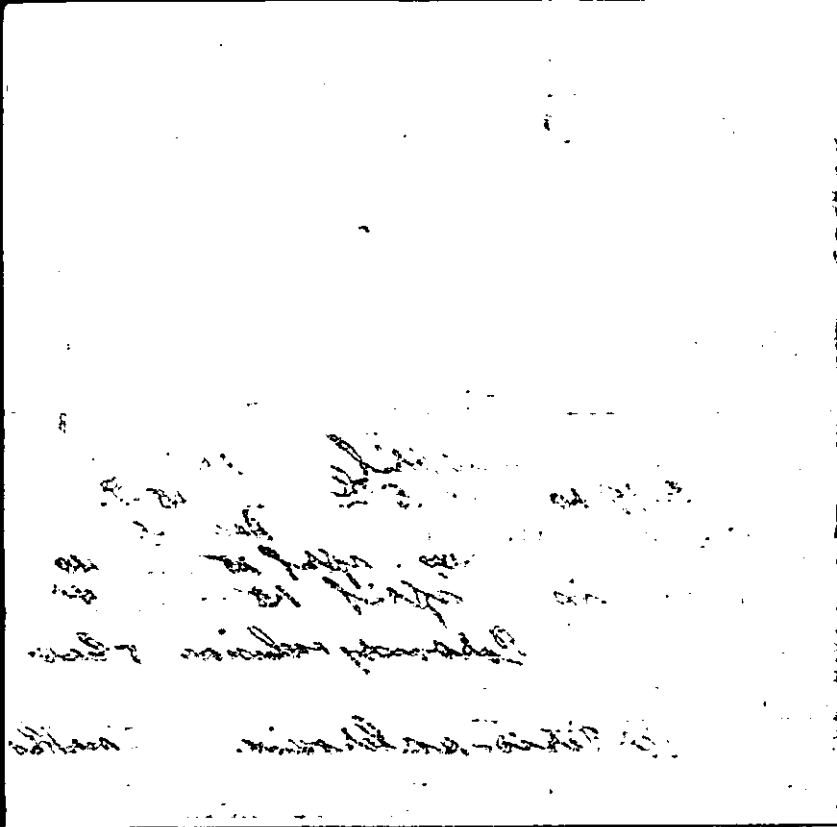
		Duration
Immediate cause of death	Coronary occlusion	5 hrs.
Due to	arterio-sclerosis	5 mths
Due to	94B	
Other conditions (Include pregnancy within 3 months of death)		
Major findings: Of operations		
Of autopsy	none	

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? ____ (e) Means of injury ____

23. Signature James Middleton (M. D. or other)
Address 324 N. Mayfield   Date signed 4-16-40

(Licensed Embalmer's Statement on Reverse Side)



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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed Charles M Quinn

Licensed Embalmer No. 3774

P. O. Address K. C., Mo.

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

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

No. 2
-10-39
17-39
X21492

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 15-1[illegible]

Primary Registration District No. _____

Registrar's No. 1641

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town K C Mo
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days)

In this community _____

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____
(If outside city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Ambrose Ballinger

3. (b) If veteran, name war _____

3. (c) Social Security No. 490-16-2158

4. Sex M

5. Color or race Wh

6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years	Months	Days	If less than one day
			hr. _____ min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

FATHER
12. Name _____
13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

MOTHER
14. Maiden name _____
15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (Burial, cremation, or removal) (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (Date received by local registrar) (b) M. M. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 15

year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw h_____ alive on _____, 19____;

and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death _____	
Due to _____	
Due to _____	
Other conditions _____ (Include pregnancy within 3 months of death)	

PHYSICIAN

Underline the cause to which death should be charged statistically.

Major findings:
Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____ (Specify type of place)

While at work? _____ (e) Means of injury _____

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

(Licensed Embalmer's Statement on Reverse Side)

S-13930

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....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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

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