

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

17500

2027

Registrar's No.

Registration District No. 399

Primary Registration District No. 1002

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:
440 West 35th Street
(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) 20 years

3. (a) PRINT FULL NAME Mrs. Lillie E. Batchelor

3. (b) If veteran, name war no 3. (c) Social Security No. no

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased February 8, 1861
(Month) (Day) (Year)

8. AGE: Years 79 Months 3 Days 7 If less than one day _____ hr. _____ min.

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

10. Usual occupation At home

11. Industry or business _____

12. Name Thomas T. James
13. Birthplace Ohio
(City, town, or county) (State or foreign country)

14. Maiden name Amanda Spender
15. Birthplace Ohio
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Lillie E. Batchelor

(b) Address The nurse, 220 E. 42nd St. N.Y.C.

17. (a) Burial (b) Date thereof May 17, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Osage City, Kansas

18. (a) Signature of funeral director Freeman Mortuary

(b) Address 104 W. 42nd St., K.C., Mo.

19. (a) May 16, 1940 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 440 West 35th Street
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 15, year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from Feb -, 1940, to May 15, 1940
that I last saw her alive on May 15, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchitis -
Pneumonia - terminal
by extensive heart
Due to Widow 3-4 yrs
nephrosclerosis 31 yrs
Due to _____

Other conditions Arterio-sclerosis
(Include pregnancy within 3 months of death)

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? _____

While at work? _____ (Specify type of place) (e) Means of injury 1

23. Signature Don Carlos Smith (M. D. or other) MD

Address 531 Ogden Bldg Date signed 5-15-40

Duration

4 days

3-4 yrs

31 yrs

5-10 yrs

PHYSICIAN

Underline the cause to which death should be charged statistically

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 Elmer C. Reddick

Licensed Embalmer No. 3495

P. O. Address Kansas, Ky.

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.