

S. No. 41-10 9  
5-17-39  
X21492

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED OCT 12 1940

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 31343

Registration District No. 56 Primary Registration District No. 5087 Registrar's No.

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

1. PLACE OF DEATH: *Bates Improvement*  
(a) County *Bates*  
(b) City or town *Worland 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 *2*  
(Specify whether  
In this community *2*  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State *Missouri* (b) County *Bates*  
(c) City or town *Worland*  
(If outside city or town limit, write "RURAL")  
(d) Street No. *0*  
(If rural, give location)  
(e) If foreign born, how long in U. S. A? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME *BILL McBATH*  
3. (b) If veteran, name war \_\_\_\_\_  
3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month *Oct* day *9*  
year *1940* hour *3* minute *15* A.M.  
21. I hereby certify that I attended the deceased from *Oct 8<sup>th</sup>*  
\_\_\_\_\_ 19*40*, to \_\_\_\_\_ 19\_\_\_\_.

4. Sex *M* 5. Color or race *W* 6. (a) Single, widowed, married, divorced *M*  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased *1877-4-21*  
(Month) (Day) (Year)

that I last saw him alive on *Oct 8<sup>th</sup>* 19*40*, and that death occurred on the date and hour stated above.  
Immediate cause of death *Carcinoma of Orbit & Metastases to Brain*

8. AGE: Years *63* Months *5* Days *18* If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Duration \_\_\_\_\_  
Due to \_\_\_\_\_  
Due to *5/2*

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

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)  
Major findings: *Carcinoma of Orbit*  
Of operations \_\_\_\_\_  
Of autopsy *none*

10. Usual occupation \_\_\_\_\_  
11. Industry or business *Farmer*

MOTHER FATHER  
12. Name *Tom Mc Bath*  
18. Birthplace *Mo.*  
(City, town, or county) (State or foreign country)  
14. Maiden name *Marcel Beardsley*  
16. Birthplace *Kans*  
(City, town, or county) (State or foreign country)

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

16. (a) Informant *A. W. Mc Bath*  
(b) Address *Worland Mo.*

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? \_\_\_\_\_

17. (a) *Burial* (b) Date thereof *Oct 11, 1940*  
(Burial, cremation, or disposal) (Month) (Day) (Year)  
(c) Place of burial or cremation *Home*  
18. (a) Signature of funeral director *Booth Funeral Home*  
(b) Address *Rich Hill Mo.*  
19. (a) \_\_\_\_\_ (b) *Mrs Norma Cobb*  
(Date received local registrar) (Registrar's signature)

995  
23. Signature *Cyrteton Hall* (M. D. or other) \_\_\_\_\_  
Address *Pleasanton Mo.* Date signed *10-11-40*

RECEIVED

District Health Officer No. 7

District File Number 10-40-1492

Date Filed 10-14-40

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.....

*my self*

Registered Apprentice No. 3585

working under my personal supervision.

Signed

*John Underwood*

Licensed Embalmer No. 3585

P. O. Address Buller md

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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. **31343**

Registration District No. **36**

Primary Registration District No. **5087**

Registrar's No. \_\_\_\_\_

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

1. PLACE OF DEATH

(a) County **Bates**  
(b) City or town **Walnut**  
(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  
In this community \_\_\_\_\_ years, months or days)

3. (a) PRINT FULL NAME

**Bill McBeth**

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

4. Sex **m** 5. Color or race **w** 6. (a) Single, widowed, married, divorced **MARRIED**

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 **63** Months **2** Days **18** If less than one day \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof (Month) (Day) (Year)

(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) **Nov. 19** (b) **Mrs. Nora Cobb**  
(Date received local registrar) (Registrar's signature)

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.

20. DATE OF DEATH Month **Oct** day **9** year **1960** hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions (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 \_\_\_\_\_

23. Signature **Charleton H. Lee, M.D.** (Physician)  
Address **Pleasanton, Kansas** Date signed \_\_\_\_\_

\* Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTAL

10. 11. 1944

10. 11. 1944

10. 11. 1944

10. 11. 1944