

ED MAR 19 1941 98  
Registration District No. \_\_\_\_\_

Primary Registration District No. 5927

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

1. PLACE OF DEATH:

(a) County Platte  
(b) City or town Satan, Missouri  
(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 14 year  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Platte 43  
(c) City or town Satan (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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 25  
year 1941 hour 9 minute P. M.  
21. I hereby certify that I attended the deceased from Feb. 10  
1941, to Feb. 24, 1941  
that I last saw her alive on Feb. 24, 1941  
and that death occurred on the date and hour stated above.

Immediate cause of death Endocarditis Acute  
Due to Cancer of Stomach & Liver  
Due to Dementia Precox  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Duration

6 mo.

PHYSICIAN

Underline the cause to which death should be charged statistically.

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy None

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) no  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? none  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
628 (Specify type of place) \_\_\_\_\_  
While at work? \_\_\_\_\_ (e) Means of injury 9  
23. Signature R. J. Pelling (M. D. or other) D.O.  
Address W. Watson, Mo. Date signed 2/28/41

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

4. Sex 7 5. Color or race W  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Andrew Leathley  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Feb 8 1879  
(Month) (Day) (Year)

8. AGE: Years 62 Months 0 Days 19 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Platte Co 0 mo  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

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

12. Name Willard Henson

13. Birthplace Platte Co 0 mo  
(City, town, or county) (State or foreign country)

14. Maiden name Willard Henson  
Platte Co 0  
(City, town, or county) (State or foreign country)

15. Birthplace \_\_\_\_\_

16. (a) Informant Andrew Bathey

(b) Address Satan

17. (a) Burial (b) Date thereof 2-23-41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Satan

18. (a) Signature of funeral director J. B. Mill

(b) Address W. Watson mo

19. (a) 3-26-41 (b) J. B. Mill  
(Date received local registrar) (Registrar's signature)

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

3000

46

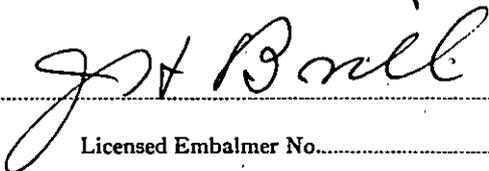
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**STATEMENT BY LICENSED EMBALMER**

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 with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**

No. 2  
-1-4-41  
-17-39  
X26390

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 2868

Registration District No. 698

Primary Registration District No. 5927

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

1. PLACE OF DEATH:

(a) County Platte  
(b) City or town Marshall T.P.  
(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 Lulu Cathey

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

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced. W

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  
62 0 17 hr. min.

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

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

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

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_ (State or foreign country)

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

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

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

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

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

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

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 25  
year 1944 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 Endocarditis (acute)

Primary seat in Stomach

Dementia Precox

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

(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature J. J. Pelly M.D. or other \_\_\_\_\_

Address W. 46th Date signed \_\_\_\_\_

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

SUPPLEMENT

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**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 with the above constitutes grounds for revocation of license.)**

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