

Registration District No. 449-176 Primary Registration District No. 5630 4278 Registrar's No. 55

1. PLACE OF DEATH:

(a) County Lawrence  
(b) City or town Miller  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: L /  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2  
In this community Sixty-three years  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lawrence  
(c) City or town Miller  
(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 -

3. (a) PRINT FULL NAME

Mary Ann Batey

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

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced, widow 2  
6. (b) Name of husband or wife L 6. (c) Age of husband or wife if alive - years  
7. Birth date of deceased 5 - 6 - 1852  
(Month) (Day) (Year)

8. AGE: Years 91 Months 7 Days 27 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

12. Name John Batey  
13. Birthplace England H  
(City, town, or county) (State or foreign country)  
14. Maiden name Unknown  
15. Birthplace England H  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Siles Kibby  
(b) Address Miller Mo.

17. (a) Burial (b) Date thereof 1-5-43  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Round Grove

18. (a) Signature of funeral director M. Miller  
(b) Address Miller Mo.

19. (a) J. J. Whimery (b) Date received local registrar 2-4-44 (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 3  
year 1944 hour 4 minute 20 P. M.

21. I hereby certify that I attended the deceased from 12-31 1943 to 1-3 1944  
that I last saw him alive on 1-2 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death: Labor for pneumonia  
Duration

Due to  
Due to

Other conditions: 108  
(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 W. J. B... (M. D. or other)  
Address Miller Mo. Date signed 1-5-44

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

MOTHER FATHER

RECEIVED

District Health Officer No. 6,

District File Number. 244-302

Date Filed FEB 12 1944

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..... E. P. Seiman .....

Licensed Embalmer No. 3297 .....

P. O. Address..... Miller 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, fact should be so stated above.

Registration District No. 176 Primary Registration District No. 4278

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(a) County Lawrence  
(b) City or town Miller  
(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 Mary Ann Batey  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 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 May 6 (Month) (Day) (Year)

8. AGE: Years 91 Months 7 Days \_\_\_\_\_ Unless than one day \_\_\_\_\_ min.

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

10. Usual occupation at home

11. Industry or business retired

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) \_\_\_\_\_ (b) Ann Whaley (Date received local registrar) (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 \_\_\_\_\_ 1944 year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Duration

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

PHYSICIAN

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

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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

STANDARD CERTIFICATE OF DEATH

7582