No. 2
—1/47
5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 30355

FILED SEP 19 1947

Registration District No. 39 Primary Registration District No. 5117 Registrar's No. 15

1. PLACE OF DEATH:
(a) County Boone
(b) City or town Rural Cedar
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 7 Miles West of Ashland
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether
In this community Life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Boone
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. 7 Miles West of Ashland, Mo.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Charles Fred Batye
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Mittie Alice Batye
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Nov (Month) 18 (Day) 1887 (Year)

8. AGE: Years 59 Months 11 Days 18 If less than one day ..... hr. ..... min.

9. Birthplace ..... (City, town, or county) Mo (State or foreign country)
10. Usual occupation Farmer
11. Industry or business
FATHER
12. Name Charles A Batye
13. Birthplace ..... (City, town, or county) Missouri (State or foreign country)
MOTHER
14. Maiden name Susan Alice Senior
15. Birthplace ..... (City, town, or county) Missouri (State or foreign country)
16. (a) Informant James Batye
(b) Address Hartsburg Mo. R.F.D.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-12-1947 (Month) (Day) (Year)
(c) Place: burial or cremation Goshen Cemt
18. (a) Signature of funeral director Wm C. Burnett
(b) Address Ashland Mo.
19. (a) 9-12-47 (Date received local registrar) (b) Mrs Mildred Burnett (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 14 year 1947 hour ..... minute ..... M.
21. I hereby certify that I attended the deceased from July 15 1947, 1947, to Sept 5, 1947, that I last saw him alive on Sept 5, 1947, and that death occurred on the date and hour stated above.

Immediate cause of death heart failure
Due to myocarditis
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations none
Of autopsy none

Duration
Sudden death

PHYSICIAN
Underline the cause of 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 Hiram Ravenscroft (M. D. or other)
Address Bonneville Mo Date signed 9.12.47

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed SEP 18 1947
DEC 18 1947

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 Wm C. Burnett

Licensed Embalmer No. 3567

P. O. Address Oakland, 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.

. No. 2B
M—3-45
1 X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. OCN

Registration District No. 34 Primary Registration District No. 2717 Registrar's No. 15

1. PLACE OF DEATH:

(a) County Boone

(b) City or town Rural
(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)

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

3. (a) PRINT FULL NAME Charles Fred Baliz

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 Wid

6. (b) Name of husband or wife

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

7. Birth date of deceased Nov. 18 1888
(Month) (Day) (Year)

8. AGE: Years 59 Months 11 Days 18 If less than one day hr. min.

9. Birthplace (City, town, or county) Missouri (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 local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

10. DATE OF DEATH: Month Sept 11
year 1947 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)	

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

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY

S-30355