

FILED AUG 5 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 23725
Registrar's No. 305

BIRTH NO. _____		REG. DIST. NO. 146		PRIMARY REG. DIST. NO. 3026		Registrar's No. 305	
1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Independence		c. LENGTH OF STAY (in this place) 31 yrs		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Independence		d. STREET ADDRESS (If rural, give location) 146 E. Kansas	
d. FULL NAME OF HOSPITAL OR INSTITUTION Independence Sanitarium							
3. NAME OF DECEASED (Type or Print) Tarrancie		a. (First) I		b. (Middle) Bath		c. (Last) Bath	
4. DATE OF DEATH July 27, 1950							
5. SEX 0 male		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married		8. DATE OF BIRTH Aug. 27, 1902	
9. AGE (In years last birthday) 47		10. IF UNDER 1 YEAR Months		11. IF UNDER 1 YEAR Days		12. IF UNDER 1 YEAR Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY Gleaner Corp.		11. BIRTHPLACE (State or foreign country) Scammon, Kansas.		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Wm. Bath		13b. MOTHER'S MAIDEN NAME Nettie Corkle		14. NAME OF HUSBAND OR WIFE Irene C. Bath			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 490-09-0243		17. INFORMANT'S SIGNATURE OR NAME Mrs. Irene C. Bath, Independence, Mo.		ADDRESS	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage				INTERVAL BETWEEN ONSET AND DEATH 4 days			
ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c)							
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				331X			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES ☐ NO ☐	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 7/23, 1950, to 7/27, 1950, that I last saw the deceased alive on 7/27, 1950, and that death occurred at 3:40 P.M., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Vance E. Link, M.D.				23b. ADDRESS Independence, Mo.		23c. DATE SIGNED 7/28/50	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 7-29-50		24c. NAME OF CEMETERY OR CREMATORY Mt. Grove Cem.		24d. LOCATION (City, town, or county) (State) Independence, Mo.	
DATE REC'D BY LOCAL REG. July 28, 1950		REGISTRAR'S SIGNATURE [Signature]		FUNERAL DIRECTOR'S SIGNATURE [Signature]		ADDRESS Independence, Mo.	

(Licensed Embalmer's Statement on Reverse Side)

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

AUG 4 RECD

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____

Licensed Embalmer No. 4592

P. O. Address Indep. 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.