

S. No. 300
V. 10.48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **36618**

FILED OCT 22 1953

BIRTH NO. _____ REG. DIST. NO. **240** PRIMARY REG. DIST. NO. **4358** Registrar's No. **27**

0720

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

1. PLACE OF DEATH a. COUNTY New Madrid Co		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO b. COUNTY New Madrid	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Lilbourn, MO		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Lilbourn, MO	
c. LENGTH OF STAY (in this place) 30 y.		d. STREET ADDRESS (If rural, give location) Non	
d. FULL NAME OF HOSPITAL OR INSTITUTION William W. Batson			

3. NAME OF DECEASED (Type or Print) William W. Batson	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) 9. 11. 1953
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Dec 20, 1873	9. AGE (In years last birthday) 79	IF UNDER 1 YEAR Months 81	IF UNDER 1 YEAR Days 2	IF UNDER 1 YEAR Hours 2	IF UNDER 1 YEAR Mins. 45
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Com Lab	10b. KIND OF BUSINESS OR INDUSTRY Com Lab	11. BIRTHPLACE (State or foreign country) Cobdin ILL	12. CITIZEN OF WHAT COUNTRY? U.S.
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13a. FATHER'S NAME Un. Kown	13b. MOTHER'S MAIDEN NAME Un Kown	14. NAME OF HUSBAND OR WIFE Mary Batson
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. NON	17. INFORMANT'S SIGNATURE OR NAME H.L. Parks ADDRESS: Cobdin, ILL
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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		INTERVAL BETWEEN ONSET AND DEATH Non
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myoplex		
	ANTECEDENT CAUSES Morbid 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.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 334X	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **9/11, 1953**, to **9/11, 1953**, that I last saw the deceased alive on **9/11, 1953**, and that death occurred at **2:45 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE John A. Robinson M.D. (Degree or title)	23b. ADDRESS Lilbourn MO	23c. DATE SIGNED 9/13/53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 9-12-53	24c. NAME OF CEMETERY OR CREMATORY MOUNDS	24d. LOCATION (City, town, or county) (State) Near Lilbourn, MO
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DATE REC'D BY LOCAL REG. 9-16-53	REGISTRAR'S SIGNATURE H.L. Parker Deputy	25. FUNERAL DIRECTOR'S SIGNATURE Hill Funeral Home ADDRESS Lilbourn, Mo. 20
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NOV 22 1957

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.....

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working under my personal supervision.

Student Embalmer No.....

Signed.....

J. M. Hill

Signed.....
Student Embalmer

Licensed Embalmer No.....

2622

P. O. Address.....

Helburns 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.