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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 31694

FILED OCT 9 1957

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4455

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) Kansas City — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Trinity Lutheran Hosp.—3 months — Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE ARIZONA b. COUNTY Maricopa
c. CITY OR TOWN Phoenix — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) 2122 West Hadley — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First: DORA Middle: ----- Last: BATEMAN

4. DATE OF DEATH Month Day Year: Sept. 24, 1957

5. SEX: Female
6. COLOR OR RACE: white
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: January 23, 1890
9. AGE (In years last birthday): 67 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker
10b. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (City and state or country): Paris-Dade County, Missouri
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME: Preston Johnson
13b. MOTHER'S MAIDEN NAME: Adelia Dye
14. NAME OF HUSBAND OR WIFE: unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Mrs. Florence Fowler-Phoenix, Arizona

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia Acute Viral — INTERVAL BETWEEN ONSET AND DEATH: 2 wk
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Gastro-enteritis Acute Viral (p.m.o) — 2 wk
DUE TO (c) — 492 X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Hypertensive Cardio-Vascular Renal Disease

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from Sept 12 1957, to Sept 24 1957 and last saw her alive on Sept 22 1957
Death occurred at 2:45 P. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Charles Henry MD (Degree or title)
22b. ADDRESS 1115 Grand Ave
22c. DATE SIGNED Sept 25 1957

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 9/25/57
23c. NAME OF CEMETERY OR CREMATORY: Garden Grove Cemetery
23d. LOCATION (City, town, or county) (State): Shawnee, Oklahoma

24. FUNERAL DIRECTOR ADDRESS: QUIRK & TOBIN-20 W. Linwood, K.C.Mo.
25. DATE RECD. BY LOCAL REG.: 9-25-57
26. REGISTRAR'S SIGNATURE: Neva Marshall

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

S. David Henry

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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 ....., Student Embalmer No. ..... working under my personal supervision.

Student ..... Signed E C Gibson .....
Signature of Student Embalmer

Licensed Embalmer No. 4137

P. O. Address KC 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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