

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-044799

STATE FILE NUMBER

FILED JAN 5 1959 Registration District No. 184 Primary Registration District No. 3038 Registrar's No. 154

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1. PLACE OF DEATH a. COUNTY <u>Linn</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Linn</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Brookfield</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Brookfield</u> 05826 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT on hospital, give location) HOSPITAL OR INSTITUTION <u>431 South Main</u>		Length of stay in 1b <u>1 month</u>	d. STREET ADDRESS (If outside, give location) <u>431 South Main</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>Frances Pearl-S-Batton</u>			4. DATE OF DEATH Month Day Year <u>Dec. 30, 1958</u>		
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 11, 1916</u>	9. AGE (In years last birthday) <u>42</u>	FUNDER 1 YEAR Months Days Hours Min. <u>10 19</u>	IF UNDER 24 HRS.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Practical nurse</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Nursing</u>	11. BIRTHPLACE (City and state or country) <u>Atlanta, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Harry Hadley</u>	13b. MOTHER'S MAIDEN NAME <u>Ettie Sun</u>	14. NAME OF HUSBAND OR WIFE <u>Ed Batton (deceased)</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war and dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>360-14-9495</u>	17. INFORMANT <u>Ruth Ann Bolin, Illinois, Illinois</u> Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>DOA Acute coronary accident</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Coronary artery disease and severe hypertension (From history)</u>	<u>17 yrs.</u>
	DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4201</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. I attended the deceased from Death occurred at <u>Prior to 10:31 A</u> to <u>DOA 10:31 AM</u> and last saw <u>him</u> alive on <u>December 30, 1958</u> on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <u>John W. White, D. O.</u>	22b. ADDRESS <u>Brookfield, Missouri</u>	22c. DATE SIGNED <u>12/31/58</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>Dec. 31, 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Labor Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Atlanta, Missouri</u>
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24. FUNERAL DIRECTOR <u>Hill Funeral Home, Brookfield, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>12-31-1958</u>	26. REGISTRAR'S SIGNATURE <u>Katharine Johnson Reg</u>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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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 Signature of Student Embalmer

Signed *Gerald J. Wady*

Licensed Embalmer No. *4172*
P. O. Address *Brown*

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.