

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-008093

STATE FILE NUMBER

FILED FEB 27 1959

Registration District No. 333 Primary Registration District No. 6115 Registrar's No. 31

300
1-57

1. PLACE OF DEATH a. COUNTY <u>SCOTT</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>SCOTT</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>SIKESTON</u>		c. CITY OR TOWN <u>SIKESTON</u> ¹⁰⁰⁰	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ROUTE 1</u>		d. STREET ADDRESS (If outside, give location) <u>ROUTE 1</u>	
Length of stay in lb <u>19 YRS.</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>ADIS</u> Middle <u>-</u> Last <u>BATTLE</u>			4. DATE OF DEATH Month <u>2</u> Day <u>7</u> Year <u>59</u>		
---	--	--	--	--	--

5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-20-1895</u>	9. AGE (In years last birthday) <u>64</u>	IF FUNDER 1 YEAR Months <u>1</u> Days <u>12</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
--------------------	-------------------------------	--	-----------------------------------	---	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMING</u>	10b. KIND OF BUSINESS OR INDUSTRY <u></u>	11. BIRTHPLACE (City and state or country) <u>LEE COUNTY, MISS.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
--	---	---	--

13a. FATHER'S NAME <u>WRIGHT BATTLE</u>	13b. MOTHER'S MAIDEN NAME <u>JANE LANKFORD</u>	14. NAME OF HUSBAND OR WIFE <u>-</u>
---	--	--------------------------------------

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES</u>	16. SOCIAL SECURITY NO. <u>-</u>	17. INFORMANT <u>HENRY BATTLE, CAROTHERSVILLE, MO.</u> Address
--	----------------------------------	--

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>Cerebral Hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 Month</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u></u>		
DUE TO (c) <u></u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>331x</u>		19. WAS AUTOPSY PERFORMED? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

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.)
---	--

20c. TIME OF INJURY Hour <u></u> Month, Day, Year <u></u> a.m. <u></u> p.m. <u></u>	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
---	---	--	------------------------------	--------	-------

21. I attended the deceased from <u>1-1-59</u> to <u>2-7-59</u> and last saw ^{her} him alive on <u>2-7-59</u> Death occurred at <u>Robertson R1 Mo.</u> on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>M.D. -</u>	22b. ADDRESS <u>Morehouse Mo.</u>	22c. DATE SIGNED <u>2-18-59</u>
---	-----------------------------------	---------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>2-19-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ROBINE</u>	23d. LOCATION (City, town, or county) (State) <u>BATESVILLE, MISS.</u>
--	--------------------------	--	--

24. FUNERAL DIRECTOR <u>ALVIN DOTSON, SIKESTON, MO.</u>	25. DATE RECD. BY LOCAL REG. <u>2-18-59</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>
---	---	--

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

MAR 9 1959

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 *Chris S. Marshall*

Licensed Embalmer No. *4601*
P. O. Address *St. Louis*

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.