

**FEDERAL BUREAU OF INVESTIGATION - UNITED STATES DEPARTMENT OF JUSTICE**

**U.S. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

FILED VS NOV 30 1959

157

Primary Registration District No. 3028

Registrar's No. 220

59-040642

STATE FILE NUMBER

UNRECORDED

<b>1. PLACE OF DEATH</b> a. COUNTY Jasper b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Carthage, Mo. Length of stay in this city or town 20 yrs c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION McCune-Brooks Hosp.				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Jasper c. CITY OR TOWN Carthage d. STREET ADDRESS 410 Cedar St Carthage, Mo.			
<b>3. NAME OF DECEASED</b> (Type or print) First MIDDLE LAST ODIE LESTER BATEMAN				<b>4. DATE OF DEATH</b> Month Day Year Nov. 17 1959			
<b>5. SEX</b> Male		<b>6. COLOR OR RACE</b> White		<b>7. Married</b> <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> 1-16-1872		<b>9. AGE (last birthday)</b> 87		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) ret. Mo. Pacific		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> railroad		<b>11. BIRTHPLACE</b> (City and state or country) Nevada, Mo.			
<b>12. CITIZEN OF WHAT COUNTRY</b> U. S. A.		<b>13a. FATHER'S NAME</b> A. C. Bateman		<b>13b. MOTHER'S MAIDEN NAME</b> Unknown			
<b>14. NAME OF HUSBAND OR WIFE</b> Anna B. Ferguson		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) No.		<b>16. SOCIAL SECURITY NO.</b> none			
<b>17. INFORMANT</b> Mrs. Frank Engler, 224 N. Main, Mo.		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic Carcinoma Liver &amp; Ad. Org.</i> DUE TO (b) <i>Primary Carcinoma of Colon</i> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 2 yrs. 2-3 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)			
<b>20c. TIME OF INJURY</b> Hour a.m. p.m.		Month, Day, Year		_____			
<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE			
<b>21. I attended the deceased from</b> 4-29-58, to 11-17-59 and last saw her/him alive on 11-17-59 Death occurred at 8:15 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.							
<b>22a. SIGNATURE</b> Grover S. Patterson, M.D.				<b>22b. ADDRESS</b> Carthage, Mo.			
<b>22c. DATE SIGNED</b> 11-17-59				_____			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> Burial		<b>23b. DATE</b> 11-19-59		<b>23c. NAME OF CEMETERY OR CREMATORY</b> Deehwood Cemetery			
<b>23d. LOCATION</b> (City, town, or county) (State) Nevada, Missouri		<b>24. FUNERAL DIRECTOR</b> ADDRESS Knell Mortuary Carthage, Mo.		<b>25. DATE RECD. BY LOCAL REG.</b> 11-18-59			
<b>26. REGISTRAR'S SIGNATURE</b> [Signature]							

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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

*Robert H Knell*

Licensed Embalmer No.

4459

P. O. Address

Carthage

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.