

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-037500

FILED VS NOV 7 1960

042

1000

1141

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Buchanan				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Length of stay in lb 42 Years		c. CITY OR TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 718 No. 7th (Hillside RH)			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2623 Duncan St.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MIDDLE Last BERTHA W. BATEMAN				4. DATE OF DEATH Month Day Year October 29, 1960			
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 5-21-1877	9. AGE (last birthday) 83	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (City and state or country) Centralia, Kans.		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Enos Wait			13b. MOTHER'S MAIDEN NAME Adaline M. Fuller			14. NAME OF HUSBAND OR WIFE Theo. E. Bateman	
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. None		17. INFORMANT Address J.H. Bateman Bethlehem, Pa.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerosis, cerebral + general</i>						INTERVAL BETWEEN ONSET AND DEATH <i>5 years</i>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)							
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	
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 a.m. p.m.		Month, Day, Year					
20d. INJURY OCCURRED WHILE AT WORK <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 <i>Feb 57</i> to <i>Nov 60</i> and last saw her <i>her</i> on <i>10-25-60</i> Death occurred at <i>11:25 PM</i> the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Type or sign) <i>J.J. Mothershead</i>				22b. ADDRESS <i>2623 Tudorville Ave. St. Joseph, Mo</i>		22c. DATE SIGNED <i>10-31-60</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11-2-60	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery		23d. LOCATION (City, town, or county) (State) St. Joseph, Mo.		
24. FUNERAL DIRECTOR <i>H.O. Sedwafalen & Son</i>			ADDRESS <i>St Joseph, Mo</i>		25. DATE RECD. BY LOCAL REG. <i>Nov. 2, 1960</i>	26. REGISTRAR'S SIGNATURE <i>Mrs. Clark Goodell</i>	

DOCUMENT

BY AFFIDAVIT OF J.J. Mothershead

BY AFFIDAVIT OF

R.R.4.

(Licensed Embalmer's Statement on Reverse Side)

Dr. Motter

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *Robert H. Gaper*
Licensed Embalmer No. 3308

P. O. Address St. Joseph, 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.