

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS NOV 23 1960 360

=60-044918

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. 6225 Registrar's No. 232

1. PLACE OF DEATH a. COUNTY Vernon		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Missouri b. COUNTY Christian	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Washington Township 3 yrs.	Length of stay in 1b	c. CITY OR TOWN Bruner	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Hosp. # 3	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Rural Route	Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Almeda Middle Baty Last Baty	4. DATE OF DEATH Month November Day 14 Year 1960
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5. SEX Female	6. COLOR OR RACE Wht.	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11-12-88	9. AGE (last birthday) 71	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and state or country) Christian Co., Mo.	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME (First name unknown) DIPLEY	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Alonzo Baty
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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. Unknown	17. INFORMANT Address State Hosp. # 3, Nevada, Missouri
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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) Broncho Pneumonia		INTERVAL BETWEEN ONSET AND DEATH 48 hrs.	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Coronary Vessel Disease		Years
	DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). Assoc. with Circ. Dist. with Chronic Brain Syndrome with Psychotic Reaction.	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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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.)
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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 St. Hosp. # 3, Nevada, Mo.	COUNTY _____ STATE _____
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21. I attended the deceased from **5-10-57** to **11-14-60** and last saw him alive on **11-14-60**
Death occurred at **10:00 a.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>[Signature]</i> E. Allen Pickens, M.D.	22b. ADDRESS St. Hosp. # 3, Nevada, Mo.	22c. DATE SIGNED 11-14-60
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23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 11-14-60	23c. NAME OF CEMETERY OR CREMATORY Chadwick	23d. LOCATION (City, town, or county) (State) Chadwick, Missouri
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24. FUNERAL DIRECTOR Ayre Goodwin	ADDRESS Springfield, Mo.	25. DATE RECD. BY LOCAL REG. 11-19-1960	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>
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DOCUMENT

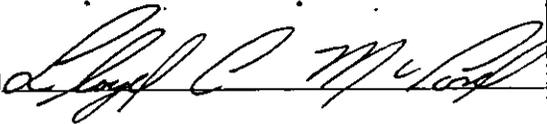
MEDICAL CERTIFICATION

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 _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed  _____

Licensed Embalmer No. 485

P. O. Address Florida

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: