

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-007402

STATE FILE NUMBER

Registration District No. 374 Primary Registration District No. 4547 Registrar's No. 3

FILED VS FEB 23 1961

AMENDED

|                                                                                                                                                            |                                                                                                           |                                                                                                                                                             |                                     |                                                                                                                                          |                                                                                |                                                                                                                                                                      |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Worth</u>                                                                                                                |                                                                                                           |                                                                                                                                                             |                                     | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>Worth</u> |                                                                                |                                                                                                                                                                      |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>Grant City</u>                                                                     |                                                                                                           | Length of stay in 1b<br><u>4 years</u>                                                                                                                      |                                     | c. CITY OR TOWN <u>Grant City,</u>                                                                                                       |                                                                                | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                                                                 |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>303 W Maple</u>                                                          |                                                                                                           | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                                                        |                                     | d. STREET ADDRESS<br><u>303 W Maple</u>                                                                                                  |                                                                                | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                                                                                |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <u>Ralph</u> Middle <u>Batt</u> Last <u>Batt</u>                                                           |                                                                                                           |                                                                                                                                                             |                                     | 4. DATE OF DEATH<br>Month <u>February</u> Day <u>6,</u> Year <u>1961</u>                                                                 |                                                                                |                                                                                                                                                                      |  |
| 5. SEX<br><u>Male</u>                                                                                                                                      | 6. COLOR OR RACE<br><u>White</u>                                                                          | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>4-1-1887</u> | 9. AGE (last birthday)<br><u>73</u>                                                                                                      | IF UNDER 1 YEAR<br>Months <u>73</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> | IF UNDER 24 HR<br>Hours <u>0</u> Min. <u>0</u>                                                                                                                       |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Ret. Farmer</u>                                          |                                                                                                           | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>own farm</u>                                                                                                        |                                     | 11. BIRTHPLACE (City and state or country)<br><u>Manango, Nebraska</u>                                                                   |                                                                                | 12. CITIZEN OF WHAT COUNTRY<br><u>U. S.</u>                                                                                                                          |  |
| 13a. FATHER'S NAME<br><u>Aaron Batt</u>                                                                                                                    |                                                                                                           | 13b. MOTHER'S MAIDEN NAME<br><u>Catherine Nutt</u>                                                                                                          |                                     | 14. NAME OF HUSBAND OR WIFE<br><u>Gertrude G. Batt</u>                                                                                   |                                                                                |                                                                                                                                                                      |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><u>no</u>                                   |                                                                                                           | 16. SOCIAL SECURITY NO.<br><u>491-09-7083</u>                                                                                                               |                                     | 17. INFORMANT<br>Address<br><u>Mrs. Gertrude G. Batt - Grant City, Mo.</u>                                                               |                                                                                |                                                                                                                                                                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> |                                                                                                           |                                                                                                                                                             |                                     |                                                                                                                                          |                                                                                | INTERVAL BETWEEN ONSET AND DEATH<br><u>1wk</u>                                                                                                                       |  |
| DUE TO (b) <u>Arteriosclerosis, generalized</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)                          |                                                                                                           |                                                                                                                                                             |                                     |                                                                                                                                          |                                                                                | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |  |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>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 <u>1959</u> to <u>Feb 6, 61</u> and last saw him alive on <u>Feb 5, 61</u>                                                |                                                                                                           | Death occurred at <u>4:45AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.                                          |                                     |                                                                                                                                          |                                                                                |                                                                                                                                                                      |  |
| 22a. SIGNATURE<br><u>Frank B Matteson M D</u> (Degree & title)                                                                                             |                                                                                                           | 22b. ADDRESS<br><u>Grant City, Mo</u>                                                                                                                       |                                     | 22c. DATE SIGNED<br><u>2/7/61</u>                                                                                                        |                                                                                |                                                                                                                                                                      |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>                                                                                                 | 23b. DATE<br><u>Feb. 8, 1961</u>                                                                          | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Honey Groove Cemetery</u>                                                                                          |                                     | 23d. LOCATION (City, town, or county) (State)<br><u>Worth County, Missouri</u>                                                           |                                                                                |                                                                                                                                                                      |  |
| 24. FUNERAL DIRECTOR<br><u>Bill A. Dunfee - Grant City, Mo.</u>                                                                                            |                                                                                                           | ADDRESS<br><u>Feb. 15 - 1961</u>                                                                                                                            |                                     | 25. DATE RECD. BY LOCAL REG.<br><u>Feb. 15 - 1961</u>                                                                                    |                                                                                |                                                                                                                                                                      |  |
| 26. REGISTRAR'S SIGNATURE<br><u>Kate E. Dawson</u>                                                                                                         |                                                                                                           |                                                                                                                                                             |                                     |                                                                                                                                          |                                                                                |                                                                                                                                                                      |  |

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SHOULD READ

ITEM NO.

**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 Bill A. Dunfee

Licensed Embalmer No. 4908

P. O. Address Grant City, 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.