

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-025253

STATE FILE NUMBER

FILED AUG 11 1958

Registration District No. 137 Primary Registration District No. 3023 Registrar's No. 849

300
1-57
422
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1. PLACE OF DEATH a. COUNTY <u>Henry</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Henry</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Clinton</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>LADUE 0420</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Netzel Osteopathic Hos</u>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>FREDRICK</u> Middle <u>Batschelett</u> Last <u>Batschelett</u>			4. DATE OF DEATH Month <u>August</u> Day <u>2</u> Year <u>1958</u>		
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 29, 1868</u>	9. AGE (In years less birthday) <u>89</u>	IF UNDER 1 YEAR Months <u>8</u> Days <u>9</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FARMER</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>ILL.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>FREDRICK BATSCHLETT</u>	13b. MOTHER'S MAIDEN NAME <u>ANNA PRIESTER</u>	14. NAME OF HUSBAND OR WIFE <u>MARY ANN BATSCHLETT</u>
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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) <u>No</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT <u>George Batschelett, Clinton, Mo.</u>	Address <u>RHS</u>
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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) <u>Medullary Paralysis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 HR</u>
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Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Cerebro Vascular Thrombosis</u>	<u>10 DAYS</u>
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DUE TO (c) <u>Generalized Arteriosclerosis</u>	<u>332x</u>	
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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 <u></u> Month, Day, Year <u></u> a.m. <u></u> p.m. <u></u>		
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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
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21. I attended the deceased from 7-22-58 to 8-2-58 and last saw ^{her} alive on 8-2-58
Death occurred at 1240 AM on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Arturo Gonzalez</u> (Degree or title)	22b. ADDRESS <u>717 E Jefferson, Clinton</u>	22c. DATE SIGNED <u>8-2-58</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>Aug. 4, 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Montrose Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Montrose, Mo.</u>
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24. FUNERAL DIRECTOR <u>H. A. Vansant, Clinton, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>8-4-58</u>	26. REGISTRAR'S SIGNATURE <u>Mildred Bigum</u>
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(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *H. A. Tausant*

Licensed Embalmer No. *3779*

P. O. Address *Clinton, Va.*

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.