

FEB 20 1940  
Registration District No. 6-67

Primary Registration District No. 6767

1. PLACE OF DEATH: Mississippi  
(a) County Mississippi  
(b) City or town Rural  
(c) Name of hospital or institution: 3  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 5 years  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Mississippi  
(c) City or town Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. 15 miles S.E. of East Prairie, Mo  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME LENA BATTIS 320  
3. (b) If veteran, name war ✓  
8. (c) Social Security No. ✓

4. Sex Female 5. Color or race colored  
6. (a) Single, widowed, married, divorced single  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife If alive \_\_\_\_\_ years  
7. Birth date of deceased Jan. 25 1936  
(Month) (Day) (Year)

8. AGE: Years 4 Months 11 Days 4 If less than one day hr. \_\_\_\_\_ min.  
4 11 4

9. Birthplace Wolf Island, Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation 9

11. Industry or business \_\_\_\_\_  
12. Name Oscar Battis  
13. Birthplace Mississippi  
(City, town, or county) (State or foreign country)  
14. Maiden name Vernice James  
15. Birthplace Mississippi  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Oscar Battis  
(b) Address Wolf Island, Missouri  
17. (a) Rural (b) Date thereof Jan. 5, 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation \_\_\_\_\_  
18. (a) Signature of funeral director Travis M. Shelby  
(b) Address East Prairie, Mo  
19. (a) Jan 5 - 1940 (b) Travis M. Shelby  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 4th  
year 1940 hour about 9:00 a.m. minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from New England 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death hit & killed by auto car  
dead in Dr. Martin's office  
Due to accidental death  
Due to \_\_\_\_\_

Other conditions (include pregnancy within 3 months of death) 7 10 11

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) accident  
(b) Date of occurrence Jan 4th 1940  
(c) Where did injury occur high way 53 near Co Mo  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
on high way 53  
While at work? chf (Specify type of place) (e) Means of injury auto 5  
23. Signature Frank J. Vernon (M. D. or other)  
Address Charleston Mo Date signed \_\_\_\_\_

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically

RECEIVED

District Health Officer No.

District File Number 240-6

Date Filed 2/29/160

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**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.....

....., Registered Apprentice No. ....  
working under my personal supervision.

Signed

*J. Travis M. Shelby*

Licensed Embalmer No. 2726

P. O. Address East Prairie, 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 this body is not embalmed, above space should be left blank.**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

3113  
Do not use this space.

1. PLACE OF DEATH  
(a) County Miss Registration District No. 567  
(b) Township Wolf Island Primary Registration District No. 2767  
(c) City..... (d) Street No..... (If death occurred in Hospital or Institution, write its name instead of street and number) St.  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Lena Batts  
(a) Residence, No. .... St.  (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 7 4. COLOR OR RACE col 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED 8 (Write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 1-25-1936

7. AGE 8 MONTHS 11 DAYS 4 If LESS than 1 day, ..... hrs. or ..... min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.....  
9. Industry or business in which work was done, as saw mill, bank, etc.....  
10. Date deceased last worked at this occupation (month and year).....  
11. Total time (years) spent in this occupation.....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER  
13. NAME  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER  
15. MAIDEN NAME  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)  
18. BURIAL, CREMATION, OR REMOVAL PLACE DATE 19.....  
19. FUNERAL DIRECTOR (ADDRESS)  
20. FILED Jan 5 1940 Mrs. B. M. Hodges Local Registrar.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 4 1940

22. I HEREBY CERTIFY That I attended deceased from 19..... to 19.....  
I last saw h..... alive on....., 19..... Death is said to have occurred on the date stated above, at..... m.  
The principal cause of death and related causes of importance were as follows:  
Date of onset

Other contributory causes of importance:

Name of operation ..... Date of.....  
What test confirmed diagnosis? ..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? ..... Date of injury....., 19.....  
Where did injury occur?..... (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....  
Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....  
If so, specify Frank S. Vernon, M. D.  
(Signed) Charleston  
(Address)

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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