

FILED NOV 14 1951

STANDARD CERTIFICATE OF DEATH

State File No. 32550

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 38 PRIMARY REG. DIST. NO. 3006 Registrar's No. 284

105  
0

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

|  |   |  |  |
|--|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>BOONE</b>  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission).<br>a. STATE <b>MISSOURI</b> b. COUNTY <b>GRUNDY</b> |  |
| b. CITY (If outside corporate limits, write RURAL and give township)<br><b>COLUMBIA</b>                                      | c. LENGTH OF STAY (In this place)<br><b>28 DAYS</b> | c. CITY (If outside corporate limits, write RURAL and give township)<br><b>TRENTON 0402</b>  |  |
| d. FULL NAME OF (If not in hospital or institution, give street address or location)<br><b>WILLIE FISHAL ST. CANCER HOSP</b> |   | d. STREET ADDRESS (If rural, give location)<br><b>808 McPHERSON 1</b>  |  |

|   |            |                         |                         |   |
|---|------------|-------------------------|-------------------------|---|
| 3. NAME OF DECEASED (Type or Print) <b>MINN</b> | a. (First) | b. (Middle) <b>BATE</b> | c. (Last) <b>BAILEY</b> | 4. DATE OF DEATH (Month) (Day) (Year)<br><b>11-7-1951</b> |
|---|------------|-------------------------|-------------------------|---|

|                      |                               |   |                                    |   |   |  |
|----------------------|-------------------------------|---|------------------------------------|---|---|--|
| 5. SEX <b>Female</b> | 6. COLOR OR RACE <b>White</b> | 7. <del>MARRIED, NEVER MARRIED,</del><br><del>WIDOWED, DIVORCED (Specify)</del><br><b>2</b> | 8. DATE OF BIRTH<br><b>1-24-88</b> | 9. AGE (In years last birthday) <b>63</b> | If UNDER 1 YEAR<br>Months <b>9</b> Days <b>14</b> | If UNDER 24 HRS.<br>Hours <b>—</b> Min. <b>—</b> |
|----------------------|-------------------------------|---|------------------------------------|---|---|--|

|   |                                   |  |   |
|---|-----------------------------------|--|---|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>PRACTICAL NURSE</b> | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country)<br><b>MISSOURI 0</b> | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |
|---|-----------------------------------|--|---|

|   |   |                             |
|---|---|-----------------------------|
| 13a. FATHER'S NAME<br><b>ALFRED J. BATE</b> | 13b. MOTHER'S MAIDEN NAME<br><b>ARABELLE GRIFFITH</b> | 14. NAME OF HUSBAND OR WIFE |
|---|---|-----------------------------|

|   |                                     |   |         |
|---|-------------------------------------|---|---------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>NO</b> | 16. SOCIAL SECURITY NO.<br><b>—</b> | 17. INFORMANT'S SIGNATURE OR NAME<br><b>Hospital Record</b> | ADDRESS |
|---|-------------------------------------|---|---------|

|   |   |  |  |
|---|---|--|--|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 1/2 yrs</b> |
|   | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Lymphosarcoma</b>   |  |  |
|   | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br><br>DUE TO (b)<br><br>DUE TO (c) |  |  |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.   |   |  |  |

|                        |   |   |
|------------------------|---|---|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION<br><b>2001</b> | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
|------------------------|---|---|

|  |  |   |
|--|--|---|
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify)           | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR?                      |

22. I hereby certify that I attended the deceased from **Oct 8, 1951**, to **Nov 7, 1951**, that I last saw the deceased alive on **Nov 7, 1951**, and that death occurred at **8:57 a.m.**, from the causes and on the date stated above.

|   |                   |  |                                    |
|---|-------------------|--|------------------------------------|
| 23a. SIGNATURE<br><b>George L. Watkins M.D.</b> | (Degree or title) | 23b. ADDRESS<br><b>State Cancer Hospital</b> | 23c. DATE SIGNED<br><b>11-7-51</b> |
|---|-------------------|--|------------------------------------|

|   |                               |                                    |   |
|---|-------------------------------|------------------------------------|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>REMOVAL</b> | 24b. DATE<br><b>11-7-1951</b> | 24c. NAME OF CEMETERY OR CREMATORY | 24d. LOCATION (City, town, or county) (State)<br><b>TRENTON MO.</b> |
|---|-------------------------------|------------------------------------|---|

|   |   |  |         |
|---|---|--|---------|
| DATE REC'D BY LOCAL REG.<br><b>Nov 7 1951</b> | REGISTRAR'S SIGNATURE<br><b>Mrs R E Palmer 31</b> | 25. FUNERAL DIRECTOR'S SIGNATURE<br><b>Parker Funeral Service Columbia Mo.</b> | ADDRESS |
|---|---|--|---------|

RECEIVED NOV 13 1951

DISTRICT HEALTH OFFICE No. 3

District File Number \_\_\_\_\_

Date Filed NOV 13 1951

NOV 30 1951

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~~ \_\_\_\_\_

working under my personal supervision.

Signed.....  
Student Embalmer

Signed *Clarence M. Bills*  
Student Embalmer No. ....

Licensed Embalmer No. *4375*

P. O. Address *Columbus 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, fact should be so stated above.