

FILED SEP 6 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

27436

1003

State File No. ....

318

PRIMARY REG. DIST. NO. ....

Registrar's No. 7128

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis, Missouri</b>		c. CITY OR TOWN <b>St. Louis</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>1026 Goodfellow Avenue.,</b>		e. STREET ADDRESS (If rural, give location) <b>1026 Goodfellow Avenue.,</b>	
3. NAME OF DECEASED (Type or Print) a. (First) <b>Lee</b> b. (Middle) c. (Last) <b>Batten</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>August 14 1955</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Feb 24, 1895</b>
9. AGE (In years last birthday) <b>60</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Inspector</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Inspector</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Wagoner Electric Advance, Missouri.</b>	
11. BIRTHPLACE (City and State or Foreign Country) <b>Advance, Missouri.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Henry Clay Batten</b>		13b. MOTHER'S MAIDEN NAME <b>Elizabeth Ann Tilman</b>	
13c. NAME OF HUSBAND OR WIFE <b>Della Inus Batten</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) <b>Yes W.W. I</b>		16. SOCIAL SECURITY NO. <b>463-42-8427</b>	
17. INFORMANT'S SIGNATURE OR NAME <b>Della Inus Batten</b>		17. ADDRESS <b>1026 Goodfellow</b>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Carcinoma of Lung</b> INTERVAL BETWEEN ONSET AND DEATH <b>6 mos</b>  ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) _____  DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION <b>June 55</b>		19b. MAJOR FINDINGS OF OPERATION <b>confirms</b>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21. ACCIDENT SUICIDE HOMICIDE (Specify)	
21a. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21b. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>163X</b>	
21c. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21e. HOW DID INJURY OCCUR?		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>10/11</b> , to <b>8-15</b> , 19 <b>55</b> , that I last saw the deceased alive on <b>8/13</b> , 19 <b>55</b> and that death occurred at _____ m., from the causes and on the date stated above.			
23a. SIGNATURE <b>Paul D. Hagemann MD</b>		23b. ADDRESS <b>3720 Washington Ave</b>	
23c. DATE SIGNED <b>8/15/55</b>		23d. DATE SIGNED	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>8-15-55</b>	
24c. NAME OF CEMETERY OR CREMATORY <b>Local</b>		24d. LOCATION (City, town, or county) (State) <b>Naylor, Missouri.</b>	
DATE REC'D BY LOCAL REG. <b>AUG 15 1955</b>		REGISTRAR'S SIGNATURE <b>J. Carl Smith MD</b>	
25. FUNERAL DIRECTOR'S SIGNATURE <b>Albert H. Hoppe</b>		25. ADDRESS <b>4700 Washington</b>	

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

(Licensed Embalmer's Statement on Reverse Side)

**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 *John J. Harris*  
Licensed Embalmer No. *419*

P. O. Address *Harris*

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.