

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

Do not use this space.

11933

1. PLACE OF DEATH

County Jackson Registration District No. 399
Township Kaw Primary Registration District No. 1002
City Kansas City No. 4608 Tracy

File No. _____
Registered No. 1720
St. _____ Ward _____

2. FULL NAME

Mrs. Myrtle Gates
(a) Residence. No. 4608 Tracy St. _____ Ward _____
(Usual place of abode) 1904 yrs. _____ mos. _____
(If nonresident give city or town and State)
Length of residence in city or town where death occurred _____ yrs. _____ mos. _____ ds. How long in U.S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F | **4. COLOR OR RACE** wh | **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 24, 1880

7. AGE

YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<u>46</u>	<u>4</u>	<u>2</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana

10. NAME OF FATHER Pete Jones

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Unknown

12. MAIDEN NAME OF MOTHER _____

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) _____

14. INFORMANT Arthur H. Gates
(Address) 4608 Tracy

15. FILED 4/27, 1927 M. M. Brown REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr. 26 1927

17. I HEREBY CERTIFY, That I attended deceased from Mar 1, 1927, to Apr 26, 1927 that I last saw her alive on Apr 26, 1927 and that death occurred, on the date stated above, at 12 noon

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute nephritis
71B (duration) _____ yrs. 2 mos. _____ ds.
CONTRIBUTORY (SECONDARY) Arteriosclerosis & Uterine Fibroma
(duration) 4 yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? _____

DID AN OPERATION PRECEDE DEATH? NO DATE OF _____

WAS THERE AN AUTOPSY? NO

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) J. S. Sheldon, M. D.

4-27, 1927 (Address) 604 Commercial Bldg

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Mt. Moriah **DATE OF BURIAL** Apr. 28, 1927

20. UNDERTAKER D. H. Newcomer **ADDRESS** 1015 E. C. M.

25-4 20-
34, 0 6 30-

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County..... Registration District No. 399 File No.
 Township..... Primary Registration District No. 1002 Registered No. 1729
 City Hanno City (No.) St. (Ward)

2. FULL NAME

Miss Myrtle Gates

(a) Residence. No. St. Ward.
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred: yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX D 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED M
(write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

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

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT (Address)

15. FILED 4/27 27 M. M. Grimes REGISTRAR
asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 26 1927

17. I HEREBY CERTIFY That I attended deceased from 19..... that I last saw h..... alive 19..... and that death occurred, on the date stated above, at

THE CAUSE OF DEATH WAS AS FOLLOWS:
Acute nephritis
Chronic pyelonephritis & uterine fibroid
non malignant
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? DATE

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) M. D.
 , 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL 19.....
 ADDRESS

20. UNDERTAKER ADDRESS

SUPPLEMENTARY

PARENTS

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.
 Exact statement of OCCUPATION is very important.

S-11933