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

37329

1 PLACE OF DEATH

County: Jefferson

Township: Central
or
Village: ~~Hillsboro~~ Mo
or
City: ..... (NO. ....., ... St., ... Ward)

Registration District No.: 4 2 2

Primary Registration District No.: 5577

File No.: .....

Registered No.: .....

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Jim Bates

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, ~~MARRIED~~, ~~WIDOWED~~, ~~OR DIVORCED~~ (Write the word)

6 DATE OF BIRTH: not known (Month) ..... (Day), 1 (Year)

7 AGE: about 55 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry business, or establishment in which employed (or employer): .....

9 BIRTHPLACE (City or town, State or foreign country): Franklin Co Mo

PARENTS

10 NAME OF FATHER: not Known

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): not Known

12 MAIDEN NAME OF MOTHER: not Known

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): not Known

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Edgar Manden Superintendent Poor Farm
(Address) Hillsboro

15 Filed Dec 12, 1927 Wayne Evans Registrar

2 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Dec (Month) 10 (Day), 1927 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Dec 1, 1927, to Dec 9, 1927, that I last saw him alive on Dec 9, 1927, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Valvular disease
7 Hrs
B 90
93A

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Nephritis Chronic

(Duration) ~~Acute~~ yrs. ..... mos. ..... ds.

(Signed) G M Mockbee M. D.

Dec 10, 1927 (Address) Hillsboro

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: Poor Farm Cemetary

DATE OF BURIAL: 12, 191.....

20 UNDERTAKER: Edgar Manden Supt County Poor Farm

ADDRESS: Hillsboro Mo R. 3

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CERTIFICATE of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

1 PLACE OF DEATH

County .....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ....., ... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH

..... (Month) ..... (Day) ....., 1..... (Year)

7 AGE ..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

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

9 BIRTHPLACE
(City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

..... (Month) ..... (Day) ....., 191..... (Year)

17 I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191.....,
that I last saw h..... alive on ....., 191.....,
and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

.....

.....

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 191.....
20 UNDERTAKER	ADDRESS

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 Jefferson Registration District No. 422 File No.
Township Central Primary Registration District No. 5577 Registered No.
City (No. St. Ward)

2. FULL NAME Jim Bates
(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
M	W	S

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)

PARENTS
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 Dec 12 1927 Mary Evans Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (month, day and year) Dec 10 1927

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

The cause of death* was as follows:

(duration) yrs. mos. ds.

CONTRIBUTORY (secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
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
Poor Farm Cemetery	Dec 10 1927

20. UNDERTAKER	ADDRESS
Edgar Marsden Supt. Poor Farm	Hillsboro Mo.

SUPPLEMENTARY

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

REGISTRARS SHALL NOT RECEIVE A CERTIFICATE FOR FILING UNLESS ALL ITEMS ARE COMPLETE

5-37329