

OCT 15 1936

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Do not use this space.

31235

1. PLACE OF DEATH

County Jackson
 Township East
 City A.C. Mo.

Registration District No. 399
 Primary Registration District No. 1002
 (No. 402, South Cypress St. Ward)

File No. 4037
 Registered No. 4037

2. FULL NAME

Theresa Bates
 (a) Residence, No. 402 South Cypress
 (Usual place of abode)

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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widow

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 9-27-1854

7. AGE YEARS 82 MONTHS 9 DAYS 11 If LESS than 1 day, hrs. min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. At Home
 9. Industry or business in which work was done, as silk mill, 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) Germany

13. NAME Joseph Mathiasch

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

15. MAIDEN NAME Anna

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

17. INFORMANT (ADDRESS) Mrs. E. L. Shepherd
307 North Oakley

18. BURIAL, CREMATION, OR REMOVAL
 PLACE St. Louis, Mo. DATE 9-3-1936

19. UNDERTAKER (ADDRESS) Mrs. E. L. Foster
A.C. Mo.

20. FILED 9-1-1936 M. M. Crowe, asst Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-31-1936

22. I HEREBY CERTIFY, That I attended deceased from Oct 1, 1935, to Aug 20, 1936

I last saw him alive on Aug 20, 1936. Death is said to have occurred on the date stated above, at 12:00 p.m.

The principal cause of death and related causes of importance were as follows:

Chronic Myocarditis 1935

Other contributory causes of importance:

Chronic Interstitial Nephritis 1930

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? Yes

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 R. T. Williams M. D.

(Signed) R. T. Williams M. D.

(Address) 5400 St. John St

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.

1 X704

Dr. Williams

Robert a.

5400 27 John

Re - 2659