

DECD OCT 26 1938

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

Do not use this space.

1. PLACE OF DEATH

County St. Francis Registration District No. 773 File No. 33207
 Township St. Francis Primary Registration District No. 6018A Registered No. 117
 City State Hospital #4 State Hospital #4 (Ward)

2. FULL NAME Elizabeth Bates

(a) Residence, No. St. Louis Mo. St. _____ Ward. _____
 (Usual place of abode)

Length of residence in city or town where death occurred 20 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 White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan. 2 1881

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
57 28 14

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. House wife
 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) Lesslie Mo.

FATHER 13. NAME John Benjamin

FATHER 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Not Known

MOTHER 15. MAIDEN NAME Not Known

MOTHER 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Not Known

17. INFORMANT (ADDRESS) State Hospital # 4

18. BURIAL, CREMATION, OR REMOVAL PLACE Buford Mo DATE Sept. 18 1938

19. UNDERTAKER (ADDRESS) Cullen Kelly
St. Louis Mo.

20. FILED Sept 17, 1938 T. J. Robinson Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 16 1938

22. I HEREBY CERTIFY, That I attended deceased from 10-19, 1931, to 9-16, 1938

I last saw her alive on 9-16, 1938. Death is said to have occurred on the date stated above, at 10 P.m.

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

Pulmonary Tuberculosis, chronic, far-advanced, toxic, bilateral.
Secondary enteritis (active) 1 plus Yrs.

Other contributory causes of importance: 23
Dementia Praecox - Toxic hyperthyroidism.
Hypertensive heart disease. Tuberculosis

Degeneration of adrenals
Significant
 Name of operation NO Date of _____
 What test confirmed diagnosis? Lab. & Clinical Was there an autopsy? Negrop

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? NO 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 directly related to occupation of deceased? No
 If so, specify _____

(Signed) G. T. Graves, Jr. M. D.
 (Address) Farmington, Missouri

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.

STATEMENT BY LICENSED EMBALMER

I, Chas Richardson, Licensed Embalmer No. 3167

hereby certify that the body recorded on the reverse side of this certificate was
embalmed by me L.E. _____

No. _____ or by _____

Registered Apprentice No. _____, working under my personal supervision.

Signed Chas Richardson

Licensed Embalmer No. 3167

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)