

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

35591  
 Do not use this space.

**1. PLACE OF DEATH**

(a) County Buchanan Registration District No. 35  
 (b) Township St. Joseph Primary Registration District No. 1001 Registered No. 1112  
 (c) City St. Joseph (d) Street No. Missouri Methodist Hospital St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred 3 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

**2. PRINT FULL NAME** Alberta Bates

(a) Residence, No. 6408 King Hill Avenue St.   
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Fred Bates  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) January 20, 1894  
 7. AGE YEARS 45 MONTHS 9 DAYS 9 If LESS than 1 day, hrs. or min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as housewife  
 9. Industry or business in which work was done, as 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) Mound City, (STATE OR COUNTRY) Missouri

FATHER 13. NAME John Hoover,

14. BIRTHPLACE (CITY OR TOWN) Unknown (STATE OR COUNTRY) Virginia

MOTHER 15. MAIDEN NAME Elizabeth Wiggins

16. BIRTHPLACE (CITY OR TOWN) Unknown (STATE OR COUNTRY) Virginia

17. INFORMANT Fred Bates (ADDRESS) 6408 King Hill Avenue, St. Joseph

18. BURIAL, CREMATION, OR REMOVAL Mound City, Missouri PLACE Mt. Hope Cemetery, DATE October 29, 39

19. FUNERAL DIRECTOR (NAME) Walter Meierhoffer (ADDRESS) 1302 Feraon St., St. Joseph, Mo.

20. FILED 10/28/39 19 1939 Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) October 29, 1939  
 22. I HEREBY CERTIFY, That I attended deceased from Oct 16, 1939, to Oct 28, 1939  
 I last saw her alive on Oct 28, 1939 Death is said to have occurred on the date stated above, at 11:50 a.m.  
 The principal cause of death and related causes of importance were as follows:

Circulatory failure  
Post thrombotic?  
 Other contributory causes of importance:  
Chronic appendicitis  
" endometritis "  
retained placenta  
 Name of operation Hysterectomy - Appendectomy Date of 10/16/39  
 What test confirmed diagnosis? Chad Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? Date of injury  
 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? No  
 If so, specify  
 (Signed) Walter P. Mc Donald, M. D.  
 (Address) Eighth & Jule, St. Joseph

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.

WHITE EMBALMER WITH ONFADING INK—THIS IS A PERMANENT RECORD

1 X16005

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MISSOURI BOARD OF  
EMBALMERS

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

Signed..... *H. A. Kelly* .....  
Licensed Embalmer No. *No. 3946* .....  
P.O. Address *St. Joseph, Missouri* .....

**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 this body is not embalmed, above space should be left blank.**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

35591  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Buchanan Registration District No. 85-  
 (b) Township St Joseph Primary Registration District No. 1001 Registered No. \_\_\_\_\_  
 (c) City St Joseph (d) Street No. \_\_\_\_\_ St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Alberta Bates  
 (a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m

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.
	<u>45</u>	<u>9</u>	<u>7</u>	

OCCUPATION  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
 9. Industry or business in which work was done, as 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)

FATHER  
 13. NAME  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER  
 15. MAIDEN NAME  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)  
 18. BURIAL, CREMATION, OR REMOVAL PLACE DATE 19\_\_\_\_  
 19. FUNERAL DIRECTOR (ADDRESS)  
 20. FILED \_\_\_\_\_ 19\_\_\_\_

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 27 1939

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_

I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

The principal cause of death and related causes of importance were as follows:  
Circulatory failure  
arterio-sclerosis  
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Other contributory causes of importance:  
Chc appendicitis  
Endometritis (post)  
Retroverted uterus  
M. O. McDonald, M.D.

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

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 Wilber P. McDonald M. D.  
 (Signed) \_\_\_\_\_ (Address) St Joseph mo

SUPPLEMENT

Local Registrar.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS etc. id. stat. is very important. 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 FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

