

APR 12 1940
399

State File No. 9545

Registration District No. _____

Primary Registration District No. 1002

Registrar's No. 979

1. PLACE OF DEATH:

(a) County Jackson
 (b) City or town K. C., Mo.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Research Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 5 Days
 (Specify whether years, months or days) 5 days

3. (a) PRINT FULL NAME

Ralph Thomas Bates

3. (b) If veteran,

Ralph Thos. Bates
 name war. X No. X

4. Sex Male5. Color or race White6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased

July 17 1938
 (Month) (Day) (Year)

8. AGE:

Years

Months

Days

If less than one day

1 7 14
 hr. _____ min.

9. Birthplace

Arrick, Missouri
 (City, town, or county) (State or foreign country)

10. Usual occupation

Infant

11. Industry or business _____

12. Name

Ben Bates

13. Birthplace

Missouri
 (City, town, or county) (State or foreign country)

14. Maiden name

Larue Rose

15. Birthplace

Missouri
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature

Mrs. Ben Bates

(b) Address

Arrick Missouri17. (a) Arrick

(b) Date thereof

3-7-40
 (Burial, exhumation, or removal) (Month) (Day) (Year)

(c) Place: burial or exhumation

Arrick, Mo.

18. (a) Signature of funeral director

Gibson & Son

(b) Address

Arrick, Missouri
3-3-40
 (Date received local registrar)

(b)

M. M. Crowe
 (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Ray
 (c) City or town Arrick Mo, Rural
 (If outside city or town limits, write "RURAL")
 (d) Street No. Rural Rt
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 23rd
 year 1940 hour 6 minute 50 A.M.

21. I hereby certify that I attended the deceased from 2/28/40
3/3, 1940, to 3/3, 1940;
 that I last saw him alive on 3/3, 1940;
 and that death occurred on the date and hour stated above.

Immediate cause of death _____

Duration _____

Streptococcus haemolyticus
Infection from chills
1060

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy no

PHYSICIAN _____

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____
 (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____

(Specify type of place)

(e) Means of injury /

23. Signature Harry M. Kelly (M. D. or other) _____
 Address 1624 Prof Bldg Date signed _____

Prof. B. L. G. / 1 to 4 3 8

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 E. C. Gibson

Licensed Embalmer No. 4137

P. O. Address Oriskany, Mo.

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.