

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
JUN 17 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **17428**
1955
Registrar's No.

Registration District No. **399**

Primary Registration District No. **1002**

1. PLACE OF DEATH: **Jackson**
(a) County **Jackson**
(b) City or town **Kansas City**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **K. C. General Hospital No. 1**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **8 days**
(Specify whether
In this community **19 yrs.**
years, months or days)

3. (a) PRINT FULL NAME **BATES, Jesse C. 320**
3. (b) If veteran, **no** name war
3. (c) Social Security No. **439-01-6463**

4. Sex **M** 5. Color or race **W**
6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Etzel Bates** 6. (c) Age of husband or wife if alive **36** years
7. Birth date of deceased **March 29 1902**
(Month) (Day) (Year)

8. AGE: Years **38** Months **1** Days **10** If less than one day
hr. min.

9. Birthplace **Normandy Tennessee**
(City, town, or county) (State or foreign country)

10. Usual occupation **Cook**

11. Industry or business **1**

MOTHER FATHER
12. Name **John G. Bates**
13. Birthplace **Normandy Tenn**
Etzel Huffer (State or foreign country)
14. Maiden name **Estil Springs Tenn**
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant's own signature **San Diego**
(b) Address **Records Rm**

17. (a) **Burial** (b) Date thereof **5/11/40**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **St Marys**

18. (a) Signature of funeral director **L. H. K. O. Van**
(b) Address **Linnwood**

19. (a) **May 10, 1940** (b) **M. M. Crowe**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Jackson**
(c) City or town **Kansas City**
(If outside city or town limits, write "RURAL")
(d) Street No. **1235 Penn**
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? years

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **May** day **9th**
year **1940** hour **11** minut **30** A. M.

21. I hereby certify that I attended the deceased from **5-1-40**, 19, to **5-9-40**, 19;
that I last saw him alive on **5-9-40**, 19;
and that death occurred on the date and hour stated above.

Immediate cause of death **Post operative upper left quadrant incision with necrotizing cellulitis** Duration

Due to **Diaphragmatic hernia**

Due to **127**

Other conditions **Toxic myocarditis; hemorrhagic**

(Include pregnancy within 3 months of death)
nephritis; peritonitis

Major findings:
Of operations

PHYSICIAN

Underline the cause to which death should be charged statistically

Of autopsy **See above**

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 **O. DeMama MD** (M. D. or other)

Address **Supt. K. C. Gen Hospital, K. C.** signed

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.....

Licensed Embalmer No.

P. O. Address.....

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.