

Registration District No. 791

Primary Registration District No. 1003

1. PLACE OF DEATH:

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 6  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1381 Belt Ave.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 8th  
year 1940 hour 5 minute 30 P.M.

21. I hereby certify that I attended the deceased from Aug. 9th, 1933 to Sept. 8th, 1940  
that I last saw him alive on Sept. 8th, 1940  
and that death occurred on the date and hour stated above.  
Immediate cause of death Coronary Thrombosis. Duration 3 days

Due to Arterio-sclerosis.  
Due to 946  
Other conditions Pernicious Anemia. 7 yrs.  
(Include pregnancy within 3 months of death)

PHYSICIAN  
Major findings: None.  
Of operations \_\_\_\_\_  
Of autopsy None.  
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? \_\_\_\_\_

23. Signature Guthrie D. DeJope (M. D. or other) MD  
Address 835 Univ. Club Bldg. Date signed 9-9-  
(Specify type of place) \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

8. (a) PRINT FULL NAME William Hamilton Bates  
8. (b) If veteran, name war None 8. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (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 January 8, 1861  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
79 8 0 hr. \_\_\_\_\_ min.

9. Birthplace St. Louis Mo. 0  
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Builder

11. Industry or business Contracting

12. Name Martin L. Bates

13. Birthplace Kentucky  
(City, town, or county) (State or foreign country)

14. Maiden name Margaret Hamilton

15. Birthplace Scotland  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mary E. Bates

(b) Address 1381 Belt Ave

17. (a) Burial (b) Date thereof 9/10/40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bellevue Cem.

18. (a) Signature of funeral director Charles W. ...

(b) Address 4911 Washington St. BC

19. (a) SEP 9 1940 (b) J. P. ...  
(Date received local registrar) (Registrar's signature)

N. B.—Every item of information should be fully 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 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 *Thomas K Fenwick*

Licensed Embalmer No. *3793*

P. O. Address *St Louis 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.**