

13-40
17-02

FILED NOV 25 1940

State File No. _____

Registration District No. 621 Primary Registration District No. 4772 Registrar's No. _____

1. PLACE OF DEATH:

(a) County Nodaway

(b) City or town Elmo
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 20
(Specify whether _____)

In this community 50 yrs
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Nodaway

(c) City or town Elmo
(If outside city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME EFFIE ESTELLA GATES.

3. (b) If veteran, name war _____ 3. (c) Social Security No. none

4. Sex F 5. Color or race W. 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Ira Tolbert Gates 6. (c) Age of husband or wife if alive 73 years

7. Birth date of deceased Feb. 19, 1865
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>75</u>	<u>7</u>	<u>25</u>	hr. _____ min. _____

9. Birthplace Pontiac Mich.
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name William Siddings

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

14. Maiden name Margaret Hall

15. Birthplace Not known
(City, town, or county) (State or foreign country)

16. (a) Informant Vern Gates

(b) Address Maryville Mo

17. (a) Burial (b) Date thereof Oct. 16, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Odd Fellows Cemetery

18. (a) Signature of funeral director John Price

(b) Address Maryville Mo.

19. (a) Oct 14 1940 (b) Clark D. Kern
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 14 year 1940 hour 7 minute 40a. M.

21. I hereby certify that I attended the deceased from Oct 8 to Oct 17, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary & Intestinal tuberculosis

Due to Septicemia

Due to Chlamydia Parvities

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 27 Of autopsy _____

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 J. H. Byland (M. D. or other) M.D.

Address Beaumont, Tex. Date signed 10-16-40

Duration

3

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....

John W. Price

Licensed Embalmer No. *3229*

P. O. Address *Maryville 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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **35942**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **621**

Primary Registration District No. **4372**

Registrar's No. _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County **Hodgson**

(b) City or town **Elmo**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____ (Specify whether _____ years, months or days)

3. (a) PRINT FULL NAME **Effie Estella Gates**

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex **F**

5. Color or race **W**

6. (a) Single, widowed, married, divorced **m**

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

6. (b) Name of husband or wife _____

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
75	7	25	hr. _____ min. _____

9. Birthplace _____ (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER {

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address **Elmo Mo**

19. (a) **Oct 14** (b) **Robert O'Hara** (Registrar's signature)

(Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____ (If outside city or town limits write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) If foreign born, how long in U.S.A.? _____ years

20. DATE OF DEATH: Month **Oct** day **14** year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw h. _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy _____

Duration _____

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 _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

