

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.

FILED OCT 15 1941

Registration District No. **347** Primary Registration District No. **3029**

Registrar's No. **261**

1. PLACE OF DEATH:
 (a) County Marion
 (b) City or town Hannibal
 (c) Name of hospital or institution: Levering Hosp.
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 7 days
 (Specify whether years, months or days)

3. (a) PRINT FULL NAME William Richard Gates
 3. (b) If veteran, name war _____ 3. (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 July 10 1867
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
74 2 18 hr. _____ min.

9. Birthplace Pike Co Missouri
 (City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business Own Farm

12. Name James Gates

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

14. Maiden name Ayers

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

16. (a) Informant's own signature Woyel Gates
 (b) Address New London Mo

17. (a) Burial (b) Date thereof 9/20/41
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Curryvillee Mo

18. (a) Signature of funeral director W. Fisher
 (b) Address Center MO

19. (a) Sept 24 1941 (b) W. Fisher
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County Ralls
 (c) City or town New London, Mo R F D
 (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. 1 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 18
 year 1941 hour 11; minute 15 A. M.
 21. I hereby certify that I attended the deceased from 9-13-1941 to 9-18-1941
 that I last saw him alive on 9-15-1941
 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary thrombosis
 Due to Arterio Sclerosis
 Due to General Sclerosis
 Other conditions Fract. Hip
 (Include pregnancy within 3 months of death)

Duration _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically

Major findings:
 Of operations W
 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?

While at work? _____ (Specify type of place) (e) Means of injury W
 23. Signature W. Fisher (M. D. or other)
 Address Hannibal Mo Date signed 9-23-41

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 32010

Registration District No. 547

Primary Registration District No. 3029

Registrar's No. _____

1. PLACE OF DEATH:

(a) County _____
(b) City or town _____
(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 _____ years, months or days)

3. (a) PRINT FULL NAME State, Tom Richard

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

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

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

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

8. AGE: Years _____ Months _____ Days _____ (If less than one day, in _____ min.)

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

10. Usual occupation _____

11. Industry of business _____

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)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 12/9/41 (Date received local registrar) (b) E. M. Lucke (Registrar's signature)

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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept 1941 year. hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____; that I last saw him _____ alive on _____ 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to Coronary Thrombosis

Due to Arterio Sclerosis

Due to General Senility

Other conditions Fractured hip (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy 160

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 Apr 13 - 1941 12:11

(c) Where did injury occur? at home - Room 2 (City or town) _____ (County) _____ (State) _____

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Got out of Bed at home and fell -

While at work? _____ (Specify type of place) (e) Means of injury Fall

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

32010