

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

16815

State File No. _____
Registrar's No. **2053**

FILED JUN 7 1943
Registration District No. _____

Primary Registration District No. **1002**

1. PLACE OF DEATH:
(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: **1109 Paseo**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **39 years** (Specify whether years, months or days)
In this community **39 years**

3. (a) PRINT FULL NAME **William Bates**
(b) If veteran, name war **None**
(c) Social Security No. **492-18-4285**

4. Sex **Male** 5. Color or race **Col**
(a) Single, widowed, married, divorced **Married**
(b) Name of husband or wife **Lula Bates**
(c) Age of husband or wife if alive **46** years
7. Birth date of deceased **February 14, 1890**
(Month) (Day) (Year)

8. AGE: Years **53** Months **2** Days **14**
If less than one day hr. min.

9. Birthplace **Columbia S. C.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Janitor**

11. Industry or business _____

MOTHER FATHER { 12. Name **Abraham Bates**
13. Birthplace **Unknown**
14. Maiden name **Julia Ann Koontz**
15. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant **Lula Bates**
(b) Address **1109 Paseo**

17. (a) **burial** (b) Date thereof **5/3/43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Highland Cemetery**

18. (a) Signature of funeral director **Thos. M. Brown**

(b) Address **1729 Lydia**

19. (a) **5-3-43** (b) **M. M. Brown**
(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. **1109 Paseo**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **28** year **1943** hour _____ minute _____ a. m.

21. I hereby certify that I attended the deceased from **Apr 18** to **Apr 28**, 19**43**
that I last saw him alive on **Apr 25**, 19**43**
and that death occurred on the date and hour stated above.
Immediate cause of death **Uremia** Duration _____

Due to **Retention of urine from enlarged prostate gland**
Due to _____
Other conditions (Include pregnancy within 5 months of death) **127a**

Major findings: Of operations _____
Of autopsy _____
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) Means of injury _____

23. Signature **Thos. M. Brown** (M.D. or other) _____
Address **1729 Lydia** Date signed _____

G. H. Brown.

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, fact should be so stated above.