

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 15880

Registrar's No. 10321

FILED JAN 11 1948

Registration District No. \_\_\_\_\_

Primary Registration District No. 2000

1. PLACE OF DEATH: **GREENE**

(a) County \_\_\_\_\_

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

(c) Name of hospital or institution: Home 821 Washington  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community 20 Years  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene

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

(d) Street No. 821 Washington  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Charlotte Catherine Bates

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex F M / 5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife S.S. Bates

6. (c) Age of husband or wife if alive 73 years

7. Birth date of deceased Aug. 22, 1870  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

73 3 26 hr. min.

9. Birthplace Anoka, Minn. Maine  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Elijah Sabin Rogers

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

14. Maiden name Frank Isabelle Legg

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

16. (a) Informant Mrs. Marshall Cassidy

(b) Address 821 Washington, Springfield

17. (a) Burial (b) Date thereof 12-20, 1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenlawn

18. (a) Signature of funeral director Dunn Funeral Home

(b) Address 629 W. Walnut, Springfield

19. (a) 1-5-44 (b) S. M. Landry  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 18 th.  
year 1943 hour 10 minute 55 A. M.

21. I hereby certify that I attended the deceased from 12-17-1943 to 12-17-1943  
that I last saw him alive on 12-17-1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Arterial Disease

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: 13/a  
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 Henry F. Cassidy (M. D. or other)

Address 4501 E. 6th St. Springfield, Mo. Date signed 1/5/44

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

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**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.....

*Charles W. McRae*

Licensed Embalmer No.....

*28911*

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.**