

U. S. No. 2  
FORM-5-43  
Rev. 5-17-39  
I X36671

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 48  
Registrar's No. 304

FILED FEB 27 1944

Registration District No. 818 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: Mo. Baptist Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2 wks.  
(Specify whether)

3. (a) PRINT FULL NAME Margaret K. Bates  
3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex F. 5. Color or race W. 6. (a) Single, widowed, married, divorced W. 2  
6. (b) Name of husband or wife Edgar D. Bates 6. (c) Age of husband or wife if alive years  
7. Birth date of deceased March 29th., 1873  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
70 9 10 hr. min.

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

10. Usual occupation At Home

11. Industry or business Thomas Kilcoyne

MOTHER FATHER

12. Name Thomas Kilcoyne  
13. Birthplace Ireland 4  
(City, town, or county) (State or foreign country)

14. Maiden name Mrs. Nerton  
15. Birthplace Ireland 4  
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. Charles R. Bates  
(b) Address 335 Planthurst Ave.

17. (a) Burial (b) Date thereof 1-12-44  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Bellefontaine

18. (a) Signature of funeral director Arthur J. Donnell  
(b) Address 3840 Lindell Blvd.

19. (a) JAN 11 1944 (b) J. S. Brink  
(Date received from informant) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo. (b) County 000  
(c) City or town St. Louis 17 5  
(If outside city or town limits, write "RURAL")  
(d) Street No. 5927 Kingsbury Blvd.  
(If rural, give location)  
(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 9th.  
year 1944 hour 3 minute 15 P. M.

21. I hereby certify that I attended the deceased from January 30 to January 9 1944  
that I last saw her alive on January 29 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis 8 yrs  
Due to 030  
Due to 030  
Other conditions: Hypertension  
(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?

23. Signature H. R. Taylor (M. D. or other)  
Address H. R. Taylor Date signed 1/10/44

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 William Matre

Licensed Embalmer No. 2825

P. O. Address 4340 Lafayette

**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.**