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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 19 1944

Registration District No. 917

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 42211

Primary Registration District No. 6076

Registrar's No. 56

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution: Elms Nursing Home 4
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 days (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 006 17

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 8676 Partridge Ave
(If rural, give location)

(e) Citizen of foreign country? / (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Daniel H. Bates

3. (b) If veteran, name war None

3. (c) Social Security No.

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Not mentioned

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

7. Birth date of deceased December 10, 1860 (Month) (Day) (Year)

8. AGE: Years 83 Months 0 Days 29 If less than one day ____hr. ____min.

9. Birthplace Elsah (City, town, or county) Illinois / (State or foreign country)

10. Usual occupation Carpenter

11. Industry or business

FATHER
12. Name James Bates
13. Birthplace Elsah (City, town, or county) Ills. / (State or foreign country)

MOTHER
14. Maiden name Cynthia Scott
15. Birthplace Elsah (City, town, or county) Ills. / (State or foreign country)

16. (a) Informant Mrs Clara E. Mosher
(b) Address 8676 Partridge Ave

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/10/44 (Month) (Day) (Year)
(c) Place: burial or cremation Friedens Cemetery

18. (a) Signature of funeral director Math Hermann & Son
(b) Address 2161 East Fair Ave

19. (a) JAN 10 1944 (Date received by registrar) (b) E. H. McHaran, M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 8th year 1944 hour 3:35 AM minute ____ M.

21. I hereby certify that I attended the deceased from 12-31, 1943 to 1-8, 1944 that I last saw him alive on 1-7, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Chronic Myocarditis	2yrs
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death) Chronic nephritis	?

Major findings:
Of operations
Of autopsy

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

23. Signature Eugene L. Arnold (M. D. or other) MD
Address 1449 McLaran Date signed 1/8/44

(Licensed Embalmer's Statement on Reverse Side)

JAN 24 1944

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.