

S. No. 2  
M-8-43  
5-17-39  
X37823

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

19351

FILED JUN 5 1944  
Registration District No. 260

Primary Registration District No. 6225

State File No. \_\_\_\_\_

Registrar's No. 98

1. PLACE OF DEATH:  
(a) County Wagoner  
(b) City or town Okmulgee - Washington  
(c) Name of hospital or institution State Hosp #3  
(d) Length of stay: 7 yr 1 month  
In this community same years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo (b) County Jackson  
(c) City or town Manassas, Pa  
(d) Street No. 3618 Charlotte  
(e) Citizen of foreign country? \_\_\_\_\_  
If yes, name country \_\_\_\_\_

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

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month May day 21  
year 1944 hour 12 minute 35 P.  
21. I hereby certify that I attended the deceased from Nov. 15, 1938, to May 21, 1944;  
that I last saw her alive on May 21, 1944  
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White  
6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife \_\_\_\_\_  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years

Immediate cause of death \_\_\_\_\_  
Chr. Deg. Myocarditis  
Due to Gen. Arteriosclerosis  
Other conditions 93d  
(Include pregnancy within 3 months of death)

8. AGE: Years Months Days If less than one day  
85 DK DK \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace DK Indiana  
10. Usual occupation None

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

MOTHER FATHER

11. Industry or business \_\_\_\_\_  
12. Name DK DK  
13. Birthplace DK DK  
14. Maiden name DK  
15. Birthplace DK

16. (a) Informant Hosp. Recd.  
(b) Address Nevada  
17. (a) Removal (b) Date thereof May 27 1944  
(c) Place: burial or cremation Removal to Kansas City, Mo.

22. If death was due to external causes, fill in the following:  
(c) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_  
(e) Means of injury \_\_\_\_\_  
23. Signature Char. J. Greiner (M. D. or other) \_\_\_\_\_  
Address Nevada Date signed 5/21/44

18. (a) Signature of funeral director Allen V. Stamp  
(b) Address Nevada  
19. (a) 5-22-44 (b) Bozell B. Beurek

1331

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

RECEIVED

District Health Officer No. 7

District File Number 5-44-683

Date Filed 6-2-44

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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 Allen S. Karp

Licensed Embalmer No. 10768

P. O. Address Nevada, N.

**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.**