

Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

1. PLACE OF DEATH:
 (a) County Jackson
 (b) City or town Bonanza City, Mo.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Research Hosp. - 0
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 3 days (Specify whether years, months or days)

3. (a) PRINT FULL NAME Salome Bates
 3. (b) If veteran, name war. no 3. (c) Social Security No. 00

4. Sex F 5. Color or race 00 6. (a) Single, widowed, married, divorced
 6. (b) Name of husband or wife John Bates 6. (c) Age of husband or wife if alive ✓ years
 7. Birth date of deceased unknown
 (Month) (Day) (Year)

8. AGE: Years 87 Months Days If less than one day hr. min.

9. Birthplace Ray, Mo. (City, town, or county) (State or foreign country)

10. Usual occupation House Duties

11. Industry or business

12. Name unknown

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

14. Maiden name unknown

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

16. (a) Informant Harley Bates

(b) Address Richmond, Mo.

17. (a) Burial (b) Date thereof Sept. 10 - 44
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Richmond, Mo.

18. (a) Signature of funeral director Thurman

(b) Address Richmond, Mo.

19. (a) 9-9-44 (b) N. C. Brown
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County Ray 89
 (c) City or town Richmond, Mo. 1
 (If outside city or town limits, write "RURAL")
 (d) Street No. (If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country 1

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 8
 year 1944 hour 3:30 minute P M.

21. I hereby certify that I attended the deceased from 9-6-44
 to 9-8-44, 19____, to 9-8-44, 19____;
 that I last saw her alive on 9-8-44, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary embolus

Due to Fractured right hip

Due to 18625

Other conditions (Include pregnancy within 3 months of death) 18

Major findings: Of operations

Of autopsy Pulmonary artery embolus
fractured l.t. hip

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident 089

(b) Date of occurrence 9-6-44

(c) Where did injury occur? Richmond, Mo. (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
in home

While at work? no (Specify type of place)

(e) Means of injury fall

23. Signature MDs (M.D. or other MD)

Address 2300 Holmes St. Mo. Date signed 9-8-44

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 _____

Licensed Embalmer No. 2073

P. O. Address Richmond Mo.

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.