V. S. No. 2
50M—5-42
Rev. 5-17-39
I X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 8 1944

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

33936

State File No.

Registration District No. 71 Primary Registration District No. 8012 Registrar's No. 144

1. PLACE OF DEATH:
(a) County Clay
(b) City or town Excelsior Springs,
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Excelsior Springs, Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community Entire Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Clay
(c) City or town Excelsior Springs
(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

3. (a) PRINT FULL NAME Robert Lee Bates
3. (b) If veteran, name war None
3. (c) Social Security No. None
4. Sex Male
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
7. Birth date of deceased December (Month) 21 (Day) 1867 (Year)
8. AGE: Years 76 Months 9 Days 28 If less than one day hr. min.
9. Birthplace Clay Co. (City, town, or county) Missouri (State or foreign country)
10. Usual occupation Retired Merchant
11. Industry or business
FATHER 12. Name Chas. F. Bates
13. Birthplace Ray Co. (City, town, or county) Missouri (State or foreign country)
MOTHER 14. Maiden name Elizabeth Miller
15. Birthplace Ray Co. (City, town, or county) Missouri (State or foreign country)
16. (a) Informant Earl W. Bates
(b) Address Excelsior Springs Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 22-44 (Month) (Day) (Year)
(c) Place: burial or cremation xxxxxMasonic Cemetery
18. (a) Signature of funeral director Chas. Pickard
(b) Address Excelsior Springs Mo.
19. (a) 10-22-44 (Date received local registrar) Mrs Sadie Redman (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 19 year 1944 hour 10 minute 55 P.M.
21. I hereby certify that I attended the deceased from Jan 11, 1943 to Oct. 19, 1944 that I last saw ~~him~~ alive on 10-19, 1944 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Pneumonia (Post Operative)	
Due to Prostatectomy	
Due to Carcinoma	
Other conditions Primary Anemia (Include pregnancy within 3 months of death)	

Major findings:
Of operations Carcinoma Prostate
Of autopsy None

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 J. E. Bagby (M. D. ~~or other~~)
Address Box Excelsior Springs Date signed 10-21-1944

1160

(Licensed Embalmer's Statement on Reverse Side)

NOV 16 1944

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 11-6-44

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 Earl Rapp

Licensed Embalmer No. 3458

P. O. Address Ste. Genev. 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.