

Registration District No. 3 1945

Primary Registration District No. 5251

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Chariton

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

(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Chariton

(c) City or town Mendon (Rural)
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Vera Lee Gates

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Mar 10th/1945
(Month) (Day) (Year)

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

Years	Months	Days	If less than one day
	<u>3</u>	<u>14</u>	hr. _____ min. _____

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name Lee Roy Gates

13. Birthplace Chariton Co Mo. (City, town, or county) (State or foreign country)

14. Maiden name Verna Mae Mc Collum

15. Birthplace Chariton Co Mo. (City, town, or county) (State or foreign country)

16. (a) Informant Lee Roy Gates

(b) Address Mendon Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/25/45 (Month) (Day) (Year)

(c) Place: burial or cremation New Comer

18. (a) Signature of funeral director D. L. Leonard

(b) Address Mendon Mo.

19. (a) 6-25-45 (Date received local registrar) (b) A. L. Orness (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 24 year 1945 hour 6 minute _____ P.M.

21. I hereby certify that I attended the deceased from JUNE 24 1945 to JUNE 24 1945;
that I last saw her alive on JUNE 24 1945;
and that death occurred on the date and hour stated above.

Immediate cause of death Respiratory Failure (Terminal) Duration _____

Due to Enteritis (Diarrhea) 4 days

Due to _____

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

Major findings: Of operations _____

Of autopsy 1190

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? _____

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

23. Signature D. P. Fowler M. D. or other _____ Date signed 6/25/45

Address Brunswick Mo.

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

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed 8-6-45

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~~
~~.....~~ Was Not embalmed Registered Apprentice No.
working under my personal supervision.

Signed L. L. Lipson

Licensed Embalmer No. 3970

P. O. Address Mendon MA

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.