

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 8599
Registrar's No. 231

No. 2
-12-45
-17-39
I X47070

FILED MAR 28 1947
Registration District No. _____

Primary Registration District No. 2000

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

1. PLACE OF DEATH:

(a) County Greene

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

(c) Name of hospital or institution:
1022 S. New Ave.
(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 40 Years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene

(c) City or town Springfield, Mo.
(If outside city or town limits, write "RURAL")

(d) Street No. 1022 S. New Ave.
(If rural, give location)

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

3. (a) PRINT FULL NAME WINNIE BELL BATES

3. (b) If veteran, name war NONE

3. (c) Social Security No. _____

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Garthron Eugene Bates

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

7. Birth date of deceased November 26, 1866
(Month) (Day) (Year)

8. AGE:

| | | | |
|-----------|----------|-----------|----------------------|
| Years | Months | Days | If less than one day |
| <u>80</u> | <u>3</u> | <u>17</u> | _____ hr. _____ min. |

9. Birthplace Linn County, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation NONE

11. Industry or business _____

12. Name William Grayson

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

14. Maiden name UNKNOWN

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

16. (a) Informant Mrs. Fern Christy

(b) Address 1022 S. New, Springfield, Mo.

17. (c) Burial (Burial, cremation, or removal) (b) Date thereof MAR. 10, 1947
(Month) (Day) (Year)

(c) Place: burial or cremation Greenlawn

18. (a) Signature of funeral director Fred C. Thome

(b) Address Springfield, Mo.

19. (a) 3-16-47 (Date received local registrar)

(b) W. S. Handley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 13th
year 1947 hour 1:03 P.M. minute _____ M.

21. I hereby certify that I attended the deceased from 1945, 19 _____ to March 13, 19 47
that I last saw her alive on March 12, 19 47
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial Infarction

Due to Arterio Sclerosis

Due to _____

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

PHYSICIAN

Major findings: Of operations _____

Of autopsy _____

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)

(c) Means of injury _____

23. Signature W. S. Handley (Registrar's signature)

Address _____ Date signed 3/15/47

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.....

Ralph F. Thorne

Licensed Embalmer No. 3681

P. O. Address Springfield, 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.