

FEDERAL SECURITY AGENCY

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

37999

State File No.

4619

FILED NOV 24 1947

Registration District No. 149

Primary Registration District No. 1002

Registrar's No.

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Keokuk
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 136 Main
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. (Specify whether
In this community. Unknown (Specify whether
years, months or days)

3. (a) PRINT FULL NAME ALLEN BATES

3. (b) If veteran, name war no 3. (c) Social Security No. none

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

8. AGE: Years Months Days If less than one day
app 65 hr. min.

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

10. Usual occupation

11. Industry or business

12. Name

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

14. Maiden name

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

16. (a) Informant Coroner's office

(b) Address Keokuk

17. (a) Removal (burial, cremation, or removal) (b) Date thereof: 11/5/47 (Month) (Day) (Year)

(c) Place: burial or cremation Keokuk College of Osteo

18. (a) Signature of funeral director Schultz

(b) Address City

19. (a) 11-5-47 (Date received local registrar) (b) Sheraldine Holmes (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson
(c) City or town Keokuk
(If outside city or town limits, write "RURAL")
(d) Street No. 136 Main
(If rural, give location)
(e) Citizen of foreign country? unknown (Yes or No)
If yes, name country no

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 1
year 1947 hour 7:00 minute 00 M.

21. I hereby certify that I attended the deceased from Keokuk, 1947, to Keokuk, 1947;
that I last saw him alive on 11/5/47, 1947,
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary sclerosis

Due to arteriosclerosis

Due to arteriosclerosis

Due to arteriosclerosis

Due to arteriosclerosis

Due to arteriosclerosis

Other conditions (include pregnancy within 3 months of death) arteriosclerosis

Major findings: Of operations arteriosclerosis

Of autopsy no

arteriosclerosis

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 arteriosclerosis

23. Signature James H. Walker (M. D. or other)

Address 1400 1/2 N. Main Date signed 11-2-47

PHYSICIAN

Underline the cause of which death should be charged statistically.

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.....

Ray E. Snow

Licensed Embalmer No. *2560*

P. O. Address.....

K C 7th

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.