

FILED AUG 23 1948
Registration District No. **128**

Primary Registration District No. **5465**

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

1. PLACE OF DEATH:

(a) County **Green**
(b) City or town **Rural - Campbell Twp.**
(c) Name of hospital or institution: **Rt # 4 Springfield**
(d) Length of stay: In hospital or institution **50 years**
In this community **50 years**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Green**
(c) City or town **Rural - Springfield**
(d) Street No. **4 miles West of Springfield**
(e) Citizen of foreign country? **NO**

3. (a) PRINT FULL NAME **CHARLES W. KATES**

3. (b) If veteran, name war: **—**
3. (c) Social Security No. **7**

4. Sex **M** 5. Color of race **W**
6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife: **—**
6. (c) Age of husband or wife if alive: **10 years**

7. Birth date of deceased: **March 10 1871**

8. AGE:	Years	Months	Days	If less than one day
	77	MM	5	26
				hr. min.

9. Birthplace: **Unknown**

10. Usual occupation: **Farmer**

11. Industry or business: **Retired**

12. Name: **Unknown**
13. Birthplace: **Unknown**
14. Maiden name: **Unknown**
15. Birthplace: **Unknown**

16. (a) Informant: **Mrs. Kail A. Schmitt**
(b) Address: **Springfield, MO, Rt 4**

17. (a) **Burial** (b) Date thereof: **8/8/48**

(c) Place: burial or cremation: **Brookline**

18. (a) Signature of funeral director: **R.E. Thurman**
(b) Address: **Republic, Mo.**

19. (a) **8-10-48** (b) **W.E. Handley MD**

(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **August** day **6**
year **1948** hour **6** minute **A.M.**

21. I hereby certify that I attended the deceased from **September 1, 1947** to **August 6, 1948**
that I last saw him alive on **August 5, 1948**
and that death occurred on the date and hour stated above.

Immediate cause of death: **Carcinoma of Prostate**
Duration: **1yr**

Due to: **—**
Due to: **—**
Other conditions: **—**
(Include pregnancy within 3 months of death)

Major findings: **513**
Of operations: **—**
Of autopsy: **—**

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

23. Signature: **Edm. LeCompte**
Address: **Brookline Mo**
Date signed: **8/6/48**

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.....

John L. McHobb....., Registered Apprentice No. *85*
working under my personal supervision.

Signed..... *W. E. Purman*

Licensed Embalmer No. *503*

P. O. Address. *Republic 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.