

1. PLACE OF DEATH:

(a) County **Jackson**
(b) City or town **Kansas City**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Osteopathic Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **24 hours**
(Specify whether
In this community **40 years**
years, months or days)

3. (a) PRINT
FULL NAME

John S. Bates

3. (b) If veteran,
name war

No

3. (c) Social Security
No. **None**

4. Sex **Male**
5. Color or
race **White**

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

6. (b) Name of husband or wife
Mrs. Myrtle Bates

6. (c) Age of husband or wife if
alive **53** years

7. Birth date of deceased **November 27th, 1886**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
62 0 2 hr. min.

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

10. Usual occupation **Attorney**

11. Industry or business

12. Name **Don't Know**

13. Birthplace **Don't Know**
(City, town, or county) (State or foreign country)

14. Maiden name **Don't Know**

15. Birthplace **Don't Know**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Myrtle Bates**

(b) Address **3225 Harrison Street**

17. (a) **Burial** (b) Date thereof **12-1-48**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Forest Hill Cemetery**

18. (a) Signature of funeral director **Freeman Mortuary**

(b) Address **Kansas City Missouri**

19. (a) **11-30-48** (b) **Geraldine Holmes**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**
(c) City or town **Kansas City**
(If outside city or town limits, write "RURAL")
(d) Street No. **3225 Harrison Street**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov.** day **29th.**
year **1948** hour **7** minute **20 P.M.**

21. I hereby certify that I attended the deceased from
Nov. 28 19**48** to **Nov. 29** 19**48**
that I last saw him alive on **Nov. 29** 19**48**
and that death occurred on the date and hour stated above.

Immediate cause of death
Cerebral Hemorrhage Duration **25 hrs.**
Due to **Vascular hypertension** Indefinite
Due to

Other conditions **Chronic Diabetes**
(Include pregnancy within 3 months of death)
myelitis - Chronic Paralysis
Major findings: **metastatic asphyxia**
Of operations
Of autopsy **61**

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

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?

E. I. Schindler (Specify type of place)
While at work? **—** (e) Means of injury **—**
Signature **E. I. Schindler** (M. D. or other) **D.O.**
Address **421 S. Hubert Bldg.** Date signed **11/30-48**

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.....

....., Registered Apprentice No.....,
working under my personal supervision.

Signed Walter H. Erwin

- - Licensed Embalmer No. 4352

P. O. Address Kansas City, 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.