

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

8127

State File No.

BIRTH NO. _____ REG. DIST. NO. 307 PRIMARY REG. DIST. NO. 541 Registrar's No. 512

1. PLACE OF DEATH a. COUNTY <u>St Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>ST LOUIS</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>CLAYTON</u>	c. LENGTH OF STAY (In this place) <u>2 DAYS</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>VALLEY PARK 4761</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>COUNTY HOSP.</u>		d. STREET ADDRESS (If rural, give location) <u>6TH + ST LOUIS AVES. /</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>FRANK</u> b. (Middle) _____ c. (Last) <u>BATES</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 1 1953</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>5-16-1901</u>		9. AGE (In years last birthday) <u>52</u> IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Mins. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SHOEWORKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>UNEMPLOYED</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>BOSTON MASS</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>

13a. FATHER'S NAME <u>UNKNOWN</u>		13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		14. NAME OF HUSBAND OR WIFE <u>MRS FRANK BATES</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>UNKNOWN</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>HOSPITAL RECORDS</u>	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Multiple sclerosis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>345X</u>			INTERVAL BETWEEN ONSET AND DEATH <u>16 days</u>
		II. OTHER SIGNIFICANT CONDITIONS (Conditions contributing to the death but not related to the disease or condition causing death) <u>Chronic passive congestion of lungs</u>			
19a. DATE OF OPERATION <u>2-1-53</u>		19b. MAJOR FINDINGS OF OPERATION <u>345X</u>			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 1-31-1953 to 2-1-1953, that I last saw the deceased alive on 2-1-1953, and that death occurred at 3:20 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Charles E. Nichols M.D.</u>		23b. ADDRESS <u>601 S. Brentwood Clayton Mo</u>		23c. DATE SIGNED <u>2-1-53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Anatomical</u>		24b. DATE <u>2-12-53</u>		24c. NAME OF CEMETERY OR CREMATORY <u>ANATOMICAL BOARD</u>	
		24d. LOCATION (City, town, or county) (State) <u>ST LOUIS MO</u>			

DATE REC'D BY LOCAL REG <u>2-12-53</u>		REGISTRAR'S SIGNATURE <u>Hubert R. Drake M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Rowland Mortuary Service</u>	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....

..... Student Embalmer No.

working under my personal supervision.

Student

Student Embalmer

Signed.....

Licensed Embalmer No.....

P. O. Address.....

(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.