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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33250

FILED OCT 15 1953

State File No. _____

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **8708**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS	
c. LENGTH OF STAY (in this place)		22190	
d. FULL NAME OF HOSPITAL OR INSTITUTION 2727 Mill St.		d. STREET ADDRESS (If rural, give location) 2727^a Mill St	

3. NAME OF DECEASED (Type or Print) Joseph	a. (First)	b. (Middle)	c. (Last) GATES	4. DATE OF DEATH 9-5-53	(Month)	(Day)	(Year)
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5. SEX MALE	6. COLOR OR RACE COLORED	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH APRIL 2, 1900	9. AGE (In years last birthday) 53 yrs	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 HRS. Hours	IF UNDER 1 HRS. Mins.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) EARL ARKANSAS	12. CITIZEN OF WHAT COUNTRY?
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13a. FATHER'S NAME Essex GATES	13b. MOTHER'S MAIDEN NAME CELIA BALWIN	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WORLD WAR 2	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Hattie Bradford	ADDRESS 2727 Mill St
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		19. INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Quincy Tuberculosis		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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) 002X
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **8-30**, 1953, to **9-5**, 1953, that I last saw the deceased alive on **9-4**, 1953, and that death occurred at **6 P** m., from the causes and on the date stated above.

23a. SIGNATURE J. W. Wilkinson	(Degree or title) M.D.	23b. ADDRESS 4141 Page Blvd	23c. DATE SIGNED 9-7-53
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24a. BURIAL, CREMATION, REMOVAL REMOVAL	24b. DATE 9-10-53	24c. NAME OF CEMETERY OR CREMATORY NATIONAL CEMETERY	24d. LOCATION (City, town, or county) (State) JEFFERSON BRKS MO
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DATE REC'D BY LOCAL REG. SEP 8 1953	REGISTRAR'S SIGNATURE J. Carl Smith, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE A. F. WALTON	ADDRESS 2707 STOODARD ST
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9.0. (Licensed Embalmer's Statement on Reverse Side)

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

Arthur L. Hilliard

Licensed Embalmer No. *4221*

P. O. Address *4594 Aldine*

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.