t. Health,
, & Welfare
i. Public
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FILED NOV 5 1957

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

35819
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4652

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) Kansas City — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 12 & Indiana (Fire Sta.) — Length of stay in Ib 6 wks

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Jackson
c. CITY OR TOWN Kansas City — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) 3510 E 12th St — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First JAMES Middle DOYLE Last GATES JR

4. DATE OF DEATH Month October Day 7 Year 1957

5. SEX Male **6. COLOR OR RACE** White **7.** MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH July 24 1957

9. AGE (In years on last birthday) IF UNDER 1 YEAR Months 2 Days 13 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) infant
10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country) Springfield Missouri

12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME James Doyle Gates Sr
13b. MOTHER'S MAIDEN NAME Charlotte Eleanor Jones
14. NAME OF HUSBAND OR WIFE none

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT James Doyle Gates Sr Address 3510 E 12th St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c) — 4 hr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT [ ] **SUICIDE** [ ] **HOMICIDE** [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from _____, to _____ and last saw her/him alive on _____
Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Geo C Kealhofer (Degree or title) Deputy Coroner
22b. ADDRESS 6627 Prospect K C Mo
22c. DATE SIGNED 10-7-57

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal
23b. DATE Oct 8 1957
23c. NAME OF CEMETERY OR CREMATORY Prospect Cemetery
23d. LOCATION (City, town, or county) (State) Buffalo Missouri

24. FUNERAL DIRECTOR Sheil Funeral Home **ADDRESS** Kansas City Mo
25. DATE RECD. BY LOCAL REG. 10-8-57
26. REGISTRAR'S SIGNATURE Neva Minshall

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Geo. C. Kealhofer

KP 2

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 .....
Signature of Student Embalmer

Signed Thomas A. Sheil

Licensed Embalmer No. 4954

P. O. Address F. C. Md

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.

FILED NOV 5 1957

THE DIVISION OF HEALTH OF MISSOURI

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6. COLOR OR RACE White
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH July 24 1957
9. AGE (In years last birthday) — IF UNDER 1 YEAR Months 2 Days 13 — IF UNDER 24 HRS. Hours Min.

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11. BIRTHPLACE (City and state or country) Springfield Missouri
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22c. DATE SIGNED 10-7-57

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal
23b. DATE Oct 8 1957
23c. NAME OF CEMETERY OR CREMATORY Bethel ~~Prospect~~ Cemetery
23d. LOCATION (City, town, or county) (State) Long Lane, Mo. ~~Buffalo Missouri~~

24. FUNERAL DIRECTOR Sheil Funeral Home ADDRESS Kansas City Mo
25. DATE RECD. BY LOCAL REG. 10-8-57
26. REGISTRAR'S SIGNATURE Neva Minshall

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

Geo. C. Kealhofer Items 23C, 23D amended by affidavit of funeral home 6-16-88

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