

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-040707

STATE FILE NUMBER

FILED NOV 20 1958 Registration District No. 200 Primary Registration District No. 4311 Registrar's No. 107

S. 300
1-57

1. PLACE OF DEATH a. COUNTY <u>Macon</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> COUNTY <u>Macon</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Callao</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Callao</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>-</u> Length of stay in 1b <u>-</u>		d. STREET ADDRESS (If outside, give location) <u>0610</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lillie W. Gates</u>			4. DATE OF DEATH Month Day Year <u>11-1-58</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-24-75</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>Giffard, Mo</u>	9c. AGE (In years last birthday) <u>83</u> IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Giffard, Mo</u>	10c. CITIZEN OF WHAT COUNTRY? <u>U.S. &</u>
11a. FATHER'S NAME <u>Marsh DADDEY</u>		11b. MOTHER'S MAIDEN NAME <u>Unknown</u>	
12. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		13. SOCIAL SECURITY NO. <u>-</u>	
14. NAME OF HUSBAND OR WIFE <u>Albert Gates</u>		Address <u>Callao, Mo</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebral vascular accident</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>viral pneumonia</u>			<u>3 wks</u>
DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>492X</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		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 <u>Nov. 1, 1958</u> and last saw her/him alive on <u>Nov. 1, 1958</u> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>A. L. Durdan</u> (Degree or title) <u>D.O.</u>		22b. ADDRESS <u>Macon, Missouri</u>	
22c. DATE SIGNED <u>11-14-58</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>11-5-58</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Chariton View Cem</u>		23d. LOCATION (City, town, or county) (State) <u>Giffard, Mo</u>	
24. FUNERAL DIRECTOR <u>W. S. Edwards</u> ADDRESS <u>Berwin</u>		25. DATE RECD. BY LOCAL REG. <u>11/5/58</u>	
26. REGISTRAR'S SIGNATURE <u>Ruth McNeely</u>			

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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Date Filed 11-18-58

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 *[Handwritten Signature]*

Licensed Embalmer No. *1961*
P. O. Address *Peoria 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.