

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-021598
STATE FILE NUMBER

FILED JUL 13 1959 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3064

300
1-57

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Kansas City 56 2
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 2615 E 34th St		Length of stay in lb 4 Mos.	d. STREET ADDRESS (If outside, give location) 2615 E. 34th St.
3. NAME OF DECEASED (Type or print) First BOBBY Middle RAY Last OATES		4. DATE OF DEATH Month June Day 22 , Year 1959	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 11, 1959
9. AGE (In years last birthday) 4 Months 11 Days		IF UNDER 1 YEAR Hours 11 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) never worked		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Kansas City, Kansas
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13a. FATHER'S NAME Lee Oates	
13b. MOTHER'S MAIDEN NAME Bonnie Ray Jones		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no.		16. SOCIAL SECURITY NO. -----	17. INFORMANT Mr. Lee Oates Address 2615 E. 34th St.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-Pneumonia		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) _____		491X	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Hypertrophied Thyroid Gland		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 _____ a.m. _____ p.m.	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
20e. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____	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 <i>Deputy Coroner</i>		22b. ADDRESS 1618 Lydia Ave	22c. DATE SIGNED 6/22/59
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 6-24-59	23c. NAME OF CEMETERY OR CREMATORY Highland Cemetery	23d. LOCATION (City, town, or county) (State) Kansas City, Missouri
24. FUNERAL DIRECTOR Mrs. Meek's Mortuary, K. C. Mo.	25. DATE RECD. BY LOCAL REG. 6-23-59	26. REGISTRAR'S SIGNATURE <i>neve marshall</i>	

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

L. M. Tillman

MEDICAL CERTIFICATION

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 *Myllard B Paski*

Licensed Embalmer No. *5013*

P. O. Address *K.C. 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.