

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-024984

FILED JUL 17 1959

Registration District No. 149 Primary Registration District No. 1002 STATE FILE NUMBER 3192 Registrar's No.

5. 300  
1-57

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Kansas City</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>3600 Prospect</b>		Length of stay in 1b <b>2 yrs</b>	d. STREET ADDRESS (If outside, give location) <b>3600 Prospect</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>E.</b> Last <b>BATES</b>			4. DATE OF DEATH Month <b>June</b> Day <b>29</b> Year <b>1959</b>			
--	--	--	--	--	--	--

5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan 14, 1888</b>	9. AGE (In years last birthday) <b>71</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.
--------------------	-------------------------------	---	---	---	---	-------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sales Clerk</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Sedalia, Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
---	-----------------------------------	---	---

13a. FATHER'S NAME <b>Charles Bates</b>	13b. MOTHER'S MAIDEN NAME <b>Edith Shelton</b>	14. NAME OF HUSBAND OR WIFE <b>Corrinne Bates</b>
--	---	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>348-16-6380</b>	17. INFORMANT Address <b>Mrs. Corrinne Bates, 3600 Prospect</b>
--	---	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusions</b>		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) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>4/201</b>		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 _____ a.m. _____ p.m.	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input 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 \_\_\_\_\_ and last saw <sup>her</sup>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 (Degree or title) <b>Melody McGilley Eylar</b>	22b. ADDRESS <b>1034 Rialto Bldg - K. C., Mo.</b>	22c. DATE SIGNED <b>6-30-59</b>
--	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>7-1-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Washington Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Kansas City, Mo.</b>
--	----------------------------	--	--

24. FUNERAL DIRECTOR <b>Melody-McGilley-Eylar Funeral Home</b>	ADDRESS <b>Woodland-Linwood</b>	25. DATE RECD. BY LOCAL REG. <b>6-30-59</b>	26. REGISTRAR'S SIGNATURE <b>Nevel Trinchell</b>
---	------------------------------------	--	---

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Secretary, coroner, or registrar must use only standard nomenclature in item 18. No symptoms will be listed.

JUL 8 1959

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 *Melvin Barton* .....

Licensed Embalmer No. *4902* .....  
P. O. Address *KC 710* .....

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.