

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JUL 5 1960

=60-022300

STATE FILE NUMBER

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 376

ENDED

1. PLACE OF DEATH a. COUNTY <u>Boone</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jasper</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		Length of stay in 1b <u>6 days</u>		c. CITY OR TOWN <u>Joplin</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>University of Missouri Medical Center</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>206 N. Cox</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Nettie</u> Middle <u>Sperry</u> Last <u>Gates</u>			4. DATE OF DEATH Month <u>June</u> Day <u>30</u> Year <u>1960</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>8-28-08</u>	9. AGE (last birthday) <u>51</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HR Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>		11. BIRTHPLACE (City and state or country) <u>South Dakota</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Jim Sperry</u>		13b. MOTHER'S MAIDEN NAME <u>Lillian Goodpastor</u>		14. NAME OF HUSBAND OR WIFE <u>William James Gates</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Hospital chart</u>		Address <u>Missouri University Medical Center</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>cardiac arrest</u>							INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u> <u>  </u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>angina</u>							DUE TO (c) <u>malignant hypertension</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH But not related to the terminal disease condition given in PART I (a)							
PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown							
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 <u>  </u> a.m. <u>  </u> p.m. <u>  </u>	Month, Day, Year <u>  </u> / <u>  </u> / <u>  </u>	20d. INJURY OCCURRED WHILE AT WORK <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 <u>6/24/60</u> to <u>6/30/60</u> and last saw her/him alive on <u>6/30/60</u> Death occurred at <u>11:05</u> <u>  </u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>Michael J. Arnyan MD</u> (Degree or title)			22b. ADDRESS <u>U. of Mo Med Center</u>		22c. DATE SIGNED <u>7/5/60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>7-1-1960</u>	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) <u>Joplin, Mo.</u>			
24. FUNERAL DIRECTOR <u>Parker Funeral Service, Columbia, Mo.</u> ADDRESS			25. DATE RECD. BY LOCAL REG. <u>July 1 1960</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. R. E. Palmare</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*J W Phillips*

Licensed Embalmer No.

*4897*

P. O. Address

*Columbus*

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.