

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-041710

FILED VS NOV 21 1960

Registration District No. 128

Primary Registration District No. \_\_\_\_\_

Registrar's No. 1140

STATE FILE NUMBER

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

3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Thomas</b> Last <b>Gateley</b>			4. DATE OF DEATH Month <b>November</b> Day <b>11</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>30 Aug. 1886</b>	9. AGE (last birthday) <b>74</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (City and state or country) <b>Greene County, Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13a. FATHER'S NAME <b>James J. Gateley</b>		13b. MOTHER'S MAIDEN NAME <b>Nancy T. Johnson</b>		14. NAME OF HUSBAND OR WIFE <b>Never Married</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WWI</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Henry Gateley (Brother)</b> Address <b>Rt. 5 Springfield, Mo</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Emphysema</b>		<b>9 yrs</b>
DUE TO (b) <b>Bronchiectasis</b>		<b>15 yrs</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)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
<b>Arteriosclerotic &amp; Pulmonary Heart Disease</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. Month, Day, Year _____			

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 <b>Oct 1958</b> , to <b>11/11/60</b> and last saw <sup>him</sup> <del>her</del> alive on <b>6 Sept 1960</b>		Death occurred at <b>5:30</b> a.m. on the date stated above, and to the best of my knowledge, from the causes stated.		

22a. SIGNATURE (Degree or title) <b>J. S. Callaway, M.D.</b>	22b. ADDRESS <b>1211 S. Glenstone Springfield, Missouri</b>	22c. DATE SIGNED <b>11-18-60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>11-13-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Comfort Cemetery</b>
24. FUNERAL DIRECTOR <b>Klingner Mortuary</b>	ADDRESS <b>Springfield, Mo.</b>	23d. LOCATION (City, town, or county) (State) <b>Greene County, Missouri</b>

25. DATE RECD. BY LOCAL REG. <b>11-18-60</b>	26. REGISTRAR'S SIGNATURE <b>Effie B. Melton</b>
---	---

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

jhc

(Licensed Embalmer's Statement on Reverse Side)

NOV 21 1960

FEB 28 1962

**STATEMENT BY LICENSED EMBALMER**

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

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

Signed John B. Klumner

Licensed Embalmer No. 510

P. O. Address Springfield

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to  
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.