

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

-62-035594
STATE FILE NUMBER

FILED SEP 17 1962

Registration District No. 272 Primary Registration District No. 5912 Registrar's No. 16

V. S. 300
Rev. 1-57

~~290~~
0780

1. PLACE OF DEATH a. COUNTY <u>Camden</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Camden</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Steele</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Steele #870,</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Rt 3 70</u>			Length of stay in lb <u>3 yr.</u>	d. STREET ADDRESS (If outside, give location) <u>Rt 3 0780</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Amie Mae Gates (Aldridge)</u>				4. DATE OF DEATH Month Day Year <u>9-8-62</u>			
5. SEX <u>F 3</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 2. WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-29-1962</u>		9. AGE (In years last birthday) Months Days Hours Min. <u>35 9 9</u>	IF UNDER 1 YEAR IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home work</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Sardinia Missi</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>Archie Gates</u>			13b. MOTHER'S MAIDEN NAME <u>Sullie Anderson</u>			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) <u>No</u>			16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Velma Williams Kennett 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>Fractured Skull</u>						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) <u>983X</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>Hit with club by a man</u>					
20c. TIME OF INJURY Hour Month, Day, Year <u>9-8-62</u>							
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.) <u>Farm Home</u>		20f. CITY, TOWN, OR LOCATION COUNTY STATE <u>Near Steele Camden, Mo</u>			
21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at <u>11 P.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>James G. Osburn, Coroner</u>				22b. ADDRESS <u>Wardell, Mo</u>		22c. DATE SIGNED <u>9-9-62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>9-9-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Ridge</u>		23d. LOCATION (City, town, or county) (State) <u>Kennett Mo.</u>		
24. FUNERAL DIRECTOR ADDRESS <u>Steele Mo</u>				25. DATE RECD. BY LOCAL REG. <u>9-9-62</u>		26. REGISTRAR'S SIGNATURE <u>Esther Collins</u>	

The funeral director is responsible for the proper completion of the entire certificate. This includes securing the medical certification in the specific manner required by 193.140 MoRS 1949.
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

4-10

SEP 18 1962

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 *Jim F. McClure*

Licensed Embalmer No. *5104*

P. O. Address *Steele, Missouri*

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.