

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-032521

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 418

FILED SEP 13 1963

|                                                                                                                                                                                                                                                                                                        |                                                                                                           |                                                                                                                                                                      |                                     |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Jackson</u>                                                                                                                                                                                                                                                          |                                                                                                           | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>                           |                                     |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br><u>Independence</u>                                                                                                                                                                                                                       |                                                                                                           | c. CITY OR TOWN <u>Independence</u>                                                                                                                                  |                                     |
| Length of stay in 1b<br><u>11 yrs.</u>                                                                                                                                                                                                                                                                 |                                                                                                           | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                                                                 |                                     |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>DOA Independence Sanit.</u>                                                                                                                                                                                          |                                                                                                           | d. STREET ADDRESS (If outside, give location)<br><u>809 Dakota</u>                                                                                                   |                                     |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <u>Muri</u> Middle <u>Leroy</u> Last <u>Bates</u>                                                                                                                                                                                                      |                                                                                                           | 4. DATE OF DEATH<br>Month <u>September</u> Day <u>5</u> Year <u>1963</u>                                                                                             |                                     |
| 5. SEX<br><u>Male</u>                                                                                                                                                                                                                                                                                  | 6. COLOR OR RACE<br><u>White</u>                                                                          | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>          | 8. DATE OF BIRTH<br><u>4-6-1896</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Barber</u>                                                                                                                                                                                           |                                                                                                           | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Barber</u>                                                                                                                   |                                     |
| 11. BIRTHPLACE (City and state or country)<br><u>Missouri</u>                                                                                                                                                                                                                                          |                                                                                                           | 12. CITIZEN OF WHAT COUNTRY<br><u>USA</u>                                                                                                                            |                                     |
| 13a. FATHER'S NAME<br><u>Samuel N. Bates</u>                                                                                                                                                                                                                                                           |                                                                                                           | 13b. MOTHER'S MAIDEN NAME<br><u>Lillie Rose Schultz</u>                                                                                                              |                                     |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><u>Yes WW I</u>                                                                                                                                                                         |                                                                                                           | 16. SOCIAL SECURITY NO.<br><u>unknown</u>                                                                                                                            |                                     |
| 17. INFORMANT<br><u>Mrs. Inez Bates</u>                                                                                                                                                                                                                                                                |                                                                                                           | Address<br><u>809 Dakota Indep. Mo.</u>                                                                                                                              |                                     |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Arteriosclerosis</u><br>DUE TO (b) _____<br>DUE TO (c) _____<br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. |                                                                                                           | INTERVAL BETWEEN ONSET AND DEATH                                                                                                                                     |                                     |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><u>Complained of Pain in chest</u>                                                                                                                                |                                                                                                           | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |                                     |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>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<br>COUNTY _____ STATE _____                                                                                                             |                                     |
| 21. I attended the deceased from _____, to _____ and last saw her alive on _____<br>Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.                                                                                                       |                                                                                                           |                                                                                                                                                                      |                                     |
| 22a. SIGNATURE<br>(Degree or title)<br><u>Hugh J. Owens Coroner</u>                                                                                                                                                                                                                                    |                                                                                                           | 22b. ADDRESS<br><u>152 Union Station</u>                                                                                                                             |                                     |
| 22c. NAME OF CEMETERY OR CREMATORY<br><u>Rest Haven Cemetery</u>                                                                                                                                                                                                                                       |                                                                                                           | 22d. LOCATION (City, town, or county)<br><u>Chillicothe Missouri</u>                                                                                                 |                                     |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Removal</u>                                                                                                                                                                                                                                            |                                                                                                           | 23b. DATE<br><u>Sept 7 1963</u>                                                                                                                                      |                                     |
| 24. FUNERAL DIRECTOR<br><u>Roland R. Speaks</u>                                                                                                                                                                                                                                                        |                                                                                                           | 25. DATE RECD. BY LOCAL REG.<br><u>9-6-63</u>                                                                                                                        |                                     |
| ADDRESS<br><u>Independence, Mo.</u>                                                                                                                                                                                                                                                                    |                                                                                                           | 26. REGISTRAR'S SIGNATURE<br><u>Alba L. Craig</u>                                                                                                                    |                                     |

USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SEP 19 1963

OCT 9 1963

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 Wayne Smith

Licensed Embalmer No. 5081

P. O. Address Indep. 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.

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