

1939 APR 21 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

11162
Do not use this space.

1. PLACE OF DEATH

(a) County Gasper Registration District No. 411
 (b) Township GALENA Primary Registration District No. 2002 Registered No. _____
 (c) City Johnston (d) Street No. St. Johns Hospital St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. _____ How long in U. S., if of foreign birth? yrs. mos. da. _____

2. PRINT FULL NAME

(a) Residence, No. 2026 9th Main St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Old Gates

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 3, 1851

7. AGE YEARS 87 MONTHS 8 DAYS 18 IF LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. retired
 9. Industry or business in which work was done, as saw mill, bank, etc. 2nd hand man
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Iowa

FATHER
 13. NAME Gates

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) no record

MOTHER
 15. MAIDEN NAME no record

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) no record

17. INFORMANT (ADDRESS) Wm Willifahr

18. BURIAL, CREMATION, OR REMOVAL (ADDRESS) Robinson Men Club DATE 3-23-39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Wm Willifahr

20. FILED 3-23-39 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3-21-39

22. I HEREBY CERTIFY, That I attended deceased from _____ 19, to _____ 19, I last saw him alive on March 22, 1939 Death is said to have occurred on the date stated above, at 7- PM 3/21/39

The principal cause of death and related causes of importance were as follows:

Automobile accident
Brain injury - 5 fractures
ribs on left side only
fractured clavicle

Other contributory causes of importance: walking on street and struck by car

Name of operation hip Date of 3/13/39
 What test confirmed diagnosis? _____ Was there an autopsy? yes

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? accident Date of injury 3/19/39
 Where did injury occur Joplin Jasper County Mo
 (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. on street

Manner of injury falling over a stick
 Nature of injury brain injury - 5 fractures ribs and clavicle

24. Was disease or injury in any way related to occupation of deceased? no
 If so, specify _____
 (Signed) A. St. Winchester M. D.
 (Address) Joplin, Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

I X 16603

RECEIVED

District Health Officer No. 6,

District File Number 637-858

Date Filed APR 12 1939

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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 this body is not embalmed, above space should be left blank.