

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.

JAN 8 1939

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

42757  
Do not use this space.

1. PLACE OF DEATH *Boone* 2  
 (a) County *Boone* Registration District No. *73*  
 (b) Township *Columbia* Primary Registration District No. *3006*  
 (c) City *Columbia* (d) Street No. \_\_\_\_\_ 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. ds. (f) How long in U. S., if of foreign birth? yrs. moe. ds.

2. PRINT FULL NAME *TOBIE GATES*  
 (a) Residence, No. *200 ALLEN* 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 *Male* 4. COLOR OR RACE *Negro* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Single*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *about 1835*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, .....hrs. or .....min.
<i>about 104</i>	<i>-</i>	<i>-</i>	<i>-</i>	

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *at home*

9. Industry or business in which work was done, as saw mill, bank, etc. \_\_\_\_\_

10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Don't know*

FATHER

13. NAME *Don't know* 9

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_ 9

MOTHER

15. MAIDEN NAME *Don't know* 9

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_ 9

17. INFORMANT *Mollie Phillips*  
(ADDRESS) *Columbia Missouri*

18. BURIAL, CREMATION, OR REMOVAL  
PLACE *Stevens Store* DATE *12-21-1939*

19. FUNERAL DIRECTOR *Stuart O. Parker*  
(ADDRESS) *Columbia Missouri*

20. FILED *12/21/1939* *Allie Selby*  
Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Dec 18 1939*

22. I HEREBY CERTIFY, That I attended deceased from *Dec 18 1939*, to *Dec 18 1939*  
 I last saw him alive on *Dec 18 1939*. Death is said to have occurred on the date stated above, at *9:25* m.  
 The principal cause of death and related causes of importance were as follows:  
*Pyelonephritis due to retention - due to hyphosphat prostatic*

Other contributory causes of importance: *127*

Name of operation *none* Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? *no*

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place. \_\_\_\_\_

Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
 If so, specify \_\_\_\_\_  
 (Signed) *AW Kampshardt*, M. D.  
 74 (Address) *Columbia, Mo.*

STATEMENT BY LICENSED EMBALMER

I, Stuart P. Parker, Licensed Embalmer No. 2900

hereby certify that the body recorded on the reverse side of this certificate was embalmed by me

..... L. E. ....

No. .... or by ..... Registered Apprentice No. ....

working under my personal supervision.

Signed, Stuart P. Parker

Licensed Embalmer No. 2900

**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.)**