

FILED OCT 11 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

30946

State File No. _____

3519

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 325 S. Wheeling
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution in hosp. 7-5-40 to 7-31-40
In this community 50 years 7-31-40 (Specify whether years, months or days) 2

3. (a) PRINT FULL NAME Frank Yates

3. (b) If veteran, name war No 3. (c) Social Security No. No

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced divorced

6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive -- years

7. Birth date of deceased Nov. 9 1962
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>77</u>	<u>9</u>	<u>27</u>	<u>hr. min.</u>

9. Birthplace Kentucky
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business William Yates

12. Name William Yates Kentucky

13. Birthplace Kentucky
(City, town, or county) (State or foreign country)

14. Maiden name Rebecca Summers
(City, town, or county) (State or foreign country)

15. Birthplace Kentucky
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Ida Rickord

(b) Address 325 S. Wheeling

17. (a) burial (b) Date thereof 9/3/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Courtney Cemetery

18. (a) Signature of funeral director R. V. Lindsey & Sons

(b) Address 3811 Broadway

19. (a) Sept. 7, 1940 M. M. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limit: write "RURAL")
(d) Street No. 325 S. Wheeling
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 6th
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from 7-5-40, 19____, to 9-8-40, 19____; that I last saw him alive on 9-5-40, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Aricular fibrillation

Due to Heart disease arteriosclerotic

Due to _____

Other conditions 95 P²
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy None

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
(e) Means of injury 1
23. Signature Dr. R. Thore (M. D. or other)
Med. Dir. R. C. Gen. Hospital
Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

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
Edison H. Peters, Registered Apprentice No. 271
working under my personal supervision.

Signed Roscoe Wheeler
Licensed Embalmer No. 3178
P. O. Address Wells

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.