DEPARTMENT OF COMMERCE
Bureau of the Census

FILED NOV 2 1 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 36634

Registration District No. 875 Primary Registration District No. 6162 Registrar's No. 268

8

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

1. PLACE OF DEATH:

(a) County Vernon

(b) City or town Rural

(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: State Hosp. # 3

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 yrs + 3 (Specify whether years, months or days)

In this community 6 yrs, 1 mo 24 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Vernon

(c) City or town Rural

(If outside city or town limits, write "RURAL")

(d) Street No. Washington L.P.

(If rural, give location)

(e) If foreign born, how long in U. S. A.? — years.

3. (a) PRINT FULL NAME Geo. Bates

3. (b) If veteran, name war —

3. (c) Social Security No. Unknown

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced Ding

6. (b) Name of husband or wife —

6. (c) Age of husband or wife if alive — years

7. Birth date of deceased Aug (Month) 6th (Day) 1864 (Year)

8. AGE: Years 76 Months 2 Days 22 If less than one day ___ hr. ___ min.

9. Birthplace Livingston (City, town, or county) Mo (State or foreign country) 0

10. Usual occupation Laborer 1

11. Industry or business —

FATHER
12. Name Francis Bates 1
13. Birthplace — (City, town, or county) Ohio (State or foreign country)

MOTHER
14. Maiden name Sarah Inman
15. Birthplace — (City, town, or county) Ohio (State or foreign country)

16. (a) Informant Hosp. records

(b) Address Nevada Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/29/40 (Month) (Day) (Year)

(c) Place: burial or cremation Hospital Cemet

18. (a) Signature of funeral director Ling Funeral Home

(b) Address Nevada Mo

19. (a) 10-29-40 (Date received local registrar) (b) Allen V. Hays (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 28 year 1940 hour 2 minute 30 A M.

21. I hereby certify that I attended the deceased from Jan 1st, 1940, to 10/28, 1940 that I last saw him alive on Oct 27, 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Left Hemiplegia	2 da
Due to Gen Arteriosclerosis	—
Due to Senility	—
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy no	

PHYSICIAN

Underline the cause to which death should be charged statistically.

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? 795 (Specify type of place)

While at work? (e) Means of injury

23. Signature L A Hopkins (M. D. ~~or other~~) 1

Address Nevada Mo Date signed 10/28/40

(Licensed Embalmer's Statement on Reverse Side)

97

RECEIVED
District Health Officer No. 7,
District File Number 11-40-1535
Date Filed 11-4-40

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 Clayf R Winscott

Licensed Embalmer No. 3857

P. O. Address Nevada, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

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

. No. 2B
—2-21-40
I X22659

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Registration District No. 875 Primary Registration District No. 6162 Registrar's No.

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

1. PLACE OF DEATH:
(a) County Vernon
(b) ~~City or town~~ Wash T.P.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Geo. Bates
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced S
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years
7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 76 Months 2 Days 22 If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 28 year 1940 hour minute M.
21. I hereby certify that I attended the deceased from , 19, to , 19; that I last saw him alive on , 19; and that death occurred on the date and hour stated above.
(Immediate cause of death) Left Hemiplegia — Duration
Due to Gen arterio Sclerosis
Due to Cerebral Hemorrhage
Jan
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy
SJW

PHYSICIAN — Underline the cause to which death should be charged statistically.

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? (Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY