

Registration District No. **417** Primary Registration District No. **3021**

1. PLACE OF DEATH:
(a) County **Jasper**
(b) City or town **North Center**
(c) Name of hospital or institution: **Jane Chapman Hospital**
(d) Length of stay: In hospital or institution **0**
In this community **0** years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Jasper**
(c) City or town **North Center**
(d) Street No. **827 N. Daugherty**
(e) If foreign born, how long in U. S. A. **0** years.

3. (a) PRINT FULL NAME **Lorain A. Gates**
3. (b) If veteran, name war
3. (c) Social Security No.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Jan** day **3rd**
year **1941** hour **11:30** minute **P** M.

4. Sex **Male** **5. Color or race** **White**
6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Katherine Gates**
6. (c) Age of husband or wife if alive **65** years

21. I hereby certify that I attended the deceased from
Dec 30, 19**40**, to **Jan 3**, 19**41**;
that I last saw **him** alive on **Jan 3**, 19**41**;
and that death occurred on the date and hour stated above.

8. AGE: Years **82** Months **0** Days **0**
If less than one day APPROXIMATE. hr. **0** min. **0**

Immediate cause of death **Branchopneumonia**
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) **1941**

9. Birthplace **Unknown** (City, town, or county) (State or foreign country) **9**
10. Usual occupation **Retired**
11. Industry or business **9**
12. Name **Unknown**
13. Birthplace **"** (City, town, or county) (State or foreign country)
14. Maiden name **Unknown**
15. Birthplace **"** (City, town, or county) (State or foreign country) **9**

Major findings: _____
Of operations _____
Of autopsy _____
PHYSICIAN
Underline the cause to which death should be charged statistically.

16. (a) Informant **Katherine Gates**
(b) Address **827 N. Daugherty St. City**
17. (a) Burial (b) Date thereof **Jan 7 1941**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Mount Hope Cem**
18. (a) Signature of funeral director **Walt City**
(b) Address **Walt City**
19. (a) JAN 7 41 (b) **C. T. Hutchinson**
(Date received local registrar) (Registrar's signature)

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? **711**
(Specify type of place)
While at work (c) Means of injury **2**
23. Signature **C. T. Gregory** (M. D. or other) **200**
Address **Walt City, Mo.** **1-6-41**
Date signed

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

49
6
2

49
6
2

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 Myself

Registered Apprentice No. _____

working under my personal supervision.

Signed Blayton M. Johnston

Licensed Embalmer No. 3, 922

P. O. Address Webb City, 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 this body is not embalmed, fact should be so stated above.