

No. 2  
11-10-39  
1-1  
I X2747

SEP 16 1941 744

Registration District No. 744

Primary Registration District No. 3035

Registrar's No. 82

1. PLACE OF DEATH:

(a) County Ray  
(b) City or town Richmond, Mo.  
(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)  
In this community 1 yr. years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Ray  
(c) City or town Richmond  
(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.? 0 years.

3. (a) PRINT FULL NAME Gas. M. Amate

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

4. Sex M 5. Color or race Negro  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Ligia Amate 6. (c) Age of husband or wife if alive 75 years  
7. Birth date of deceased Dec 17 - 1851  
(Month) (Day) (Year)

8. AGE: Years 89 Months 8 Days 21 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
12. Name Slave  
13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)  
14. Maiden name Marion Carral  
15. Birthplace Virginia (City, town, or county) (State or foreign country)

16. (a) Informant Ligia Amate

(b) Address Richmond

17. (a) Burial (b) Date thereof 9-11-41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Prairie Ridge

18. (a) Signature of funeral director Alspaugh

(b) Address P.O. Box

19. (a) Sept 10 - 41 (b) Maluf Jackson  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 9  
year 1941 hour 5 minute A. M.

21. I hereby certify that I attended the deceased from 9-7-41, 19\_\_\_\_, to 9-9-41, 19\_\_\_\_;  
that I last saw him alive on 9-8-41, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage

Due to Arterio-sclerosis

Due to \_\_\_\_\_

Other conditions 83 A  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
-Of operations: \_\_\_\_\_

Of autopsy: \_\_\_\_\_

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) (b) Means of injury \_\_\_\_\_

23. Signature Dr. J. C. Cook (M. D. or other) M.D.  
Address Richmond, Mo. Date signed 9-10-41

Duration 2 ds  
?   
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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

FILED  
District Health Officer No. 8,  
City File Number  
4-12-41

**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 *James A. Adams*

Licensed Embalmer No. *29086*

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.