

FILED FEB 7 1944

State File No. _____

Registration District No. 24

Primary Registration District No. 4035

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Bates
(b) City or town Rockville Mo
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ✓
(Specify whether)

In this community 10 Mo
years, months or days

3. (a) PRINT FULL NAME Orpha A Gates

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

4. Sex Fe 5. Color or race W 6. (a) Single, widowed, married, divorced None

6. (b) Name of husband or wife Jim 6. (c) Age of husband or wife if alive 55 years

7. Birth date of deceased 7-16-1884
(Month) (Day) (Year)

8. AGE: Years 59 Months 6 Days 5 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Weil Hudson

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

14. Maiden name Lucy Ann Taylor

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

16. (a) Informant Jim Bates

(b) Address Rockville Mo

17. (a) Burial (b) Date thereof 1-24-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calhoun Mo

18. (a) Signature of funeral director Fred Williams

(b) Address Clinton Mo

19. (a) Jan 23 1944 (b) Mrs. Wilbur Steiner
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Bates
(c) City or town Rockville Mo
(If outside city or town limits, write "RURAL")

(d) Street No. Rural 7 E
(If rural, give location)

(e) Citizen of foreign country? ✓ (Yes or No)

If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 21
year 1944 hour 10 minute 30 PM

21. I hereby certify that I attended the deceased from Jan 17, 1942 to Jan 23, 1944
that I last saw him alive on Jan 18, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary occlusion

Due to arteriosclerosis 5 yrs

Due to 131 5 yrs

Other conditions chronic nephritis 5 yrs
(Include pregnancy within 3 months of death)

Major findings: none performed

Of operations none performed

Of autopsy none performed

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 2

23. Signature M O Bierke (M. D. or other) MD

Address Rockville Mo Date signed 1/21/44

Duration

1 mo

5 yrs

5 yrs

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED

District Clerk, Office No. 7,

District No. 1-44-62

Date Filed 2-4-44

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.....

Licensed Embalmer No. 2498

P. O. Address Clenton 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.