S. No. 2
I—1/47
5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 26316

FILED AUG 4 1947

Registration District No. 1977

Primary Registration District No. 6076

Registrar's No. 1633

1. PLACE OF DEATH:

(a) County ST LOUIS

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

(c) Name of hospital or institution: 10417 OAK ST. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 YEARS (Specify whether
In this community " " " years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County ST LOUIS 96

(c) City or town OVERLAND 13
(If outside city or town limits, write "RURAL")

(d) Street No. 10417 OAK ST 1
(If rural, give location)

(e) Citizen of foreign country? (Yes or No) 0

If yes, name country

3. (a) PRINT FULL NAME MARY FRANCES BATES

3. (b) If veteran, name war —

3. (c) Social Security No. —

4. Sex FEMALE 1

5. Color or race WHITE

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

6. (b) Name of husband ~~or wife~~ JAMES

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

7. Birth date of deceased OCT (Month) - 19 (Day) - 1870 (Year)

8. AGE:

Years	Months	Days	If less than one day
76	9	10	hr. min.

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

10. Usual occupation RETIRED

11. Industry or business —

FATHER
12. Name JIM BATES
13. Birthplace — Mo. 0
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name ELIZBETH REARDON
15. Birthplace — IRELAND 4
(City, town, or county) (State or foreign country)

16. (a) Informant MR ROBERT BATES
(b) Address 627 N. 72ND ST. E ST LOUIS ILL.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 7-31-47 (Month) (Day) (Year)
(c) Place: burial or cremation ROLLA, MO

18. (a) Signature of funeral director ROWLAND FUNERAL SER.
(b) Address 4355 WASHINGTON AV.

19. (a) 8-1-47 (Date received local registrar) (b) Cecil A Z Sharp MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JULY day 29th
year 1947 hour 12 minute 30 p M.

21. I hereby certify that I attended the deceased from July 17 1947 to July 28 1947
that I last saw her alive on July 28 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis Chronic

Due to

Due to 93d

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

PHYSICIAN

Underline the cause of 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? 0
(Specify type of place)

While at work? (e) Means of injury

23. Signature C. E. Sterling (M. D. or other) MD

Address 2050 North & South Rd Date signed 30 July 47
St. Louis Ill 14

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

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.....Konald Yalmke.....

Licensed Embalmer No.....3917.....

P. O. Address.....4355 Washington Av

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.