

FILED AUG 14 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **22842**
Registrar's No. **123**

BIRTH NO. _____ REG. DIST. NO. **137** PRIMARY REG. DIST. NO. **3023**

1. PLACE OF DEATH a. COUNTY Henry			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY Henry		
b. CITY OR TOWN Clinton		c. LENGTH OF STAY (In this place) 1 1/2 Day	c. CITY OR TOWN Clinton		d. STREET ADDRESS (If rural, give location)
d. FULL NAME OF HOSPITAL OR INSTITUTION Clinton General Hospital					
3. NAME OF DECEASED (Type or Print) JAMES MILTON GATES			a. (First)	b. (Middle)	c. (Last)
4. DATE OF DEATH Aug. 3 1951			(Month)	(Day)	(Year)
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH April 10, 1866	9. AGE (In years last birthday) 85	10. UNDER 1 YEAR 3
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter Retired	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Henry Co. Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME W. A. Gates		13b. MOTHER'S MAIDEN NAME Virginia Blackburn		14. NAME OF HUSBAND OR WIFE None	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No.	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Mrs. Ora Munn, Wicks, Mo.	ADDRESS		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute peritonitis				INTERVAL BETWEEN ONSET AND DEATH 24 hours
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Perforated duodenal ulcer				30 hours
	DUE TO (c) None				
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None				
19a. DATE OF OPERATION None	19b. MAJOR FINDINGS OF OPERATION 5411				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) No	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Aug 2 , 1951, to Aug 3 , 1951, that I last saw the deceased alive on Aug 3 , 1951, and that death occurred at 3:20 P.M. , from the causes and on the date stated above.					
23a. SIGNATURE S. B. Hughes		(Degree or title) M.D.	23b. ADDRESS Clinton, Mo.		23c. DATE SIGNED 8/4/51
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Aug 5, 51	24c. NAME OF CEMETERY OR CREMATORY Hopewell Cemetery	24d. LOCATION (City, town, or county) (State) West Henry Co. Mo.		
DATE REC'D BY LOCAL REG. Aug. 5-51	REGISTRAR'S SIGNATURE Florence Adair	422	25. FUNERAL DIRECTOR'S SIGNATURE N. A. Vansant, Clinton, Mo.		

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

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RECEIVED 8-13-51

DISTRICT HEALTH OFFICE No. 3

District File Number _____

Date Filed 8-13-51

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~~ _____

Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed W. A. Tarrant

Licensed Embalmer No. 3779

P. O. Address Clinton, 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.