

FILED JUN 1 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **14539**

BIRTH NO. _____		REG. DIST. NO. 1	PRIMARY REG. DIST. NO. 4001	Registrar's No. 140
1. PLACE OF DEATH a. COUNTY Adair		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Adair		
b. CITY (If outside corporate limits, write RURAL and give town or township) Novinger		c. CITY (If outside corporate limits, write RURAL and give township) Novinger		
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location)		
3. NAME OF DECEASED (Type or Print) a. (First) Chloe		b. (Middle)	c. (Last) Gates	4. DATE OF DEATH (Month) (Day) (Year) May, 25, 1955
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH October 6, 1888	9. AGE (In years, last birthday) 65 ; IF UNDER 1 YEAR: Months 7 Days 19 ; IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Adair County, Missouri	12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME James Bell		13b. MOTHER'S MAIDEN NAME Catherine Ledford	14. NAME OF HUSBAND OR WIFE Ora Gates	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give way or dates of service)		16. SOCIAL SECURITY NO. 1	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Russell Wellman, Novinger, Mo.	
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary thrombosis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerosis (coronary) DUE TO (c) Senility 4-201		INTERVAL BETWEEN ONSET AND DEATH Few wks Few yrs Several
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		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 April 9, 1951 to May 24, 1955 , that I last saw the deceased alive on May 24, 1955 , and that death occurred at 10:05P. m., from the causes and on the date stated above.				
23a. SIGNATURE John R. Rodrick, D.O.		23b. ADDRESS 104 1/2 N Franklin St. Kirksville, Missouri		23c. DATE SIGNED 5/27/55
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE May 29, 1955	24c. NAME OF CEMETERY OR CREMATORY Novinger Cemetery	24d. LOCATION (City, town, or county) (State) Novinger, Missouri	
DATE REC'D BY LOCAL REG. 5-30-55	REGISTRAR'S SIGNATURE Nate Lambert	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Sherrill E. Kuntz, Novinger, Missouri		

(Licensed Embalmer's Statement on Reverse Side)

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

JUN 7 1955

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 Archib W. Wade

Licensed Embalmer No. 3037

P. O. Address Green 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.