

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

'57 022517
State File No.

FILED JUN 25 1957

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. **1003** Registrar's No. **5698**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY <input checked="" type="checkbox"/>	
b. CITY OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Home 5084 Minerva		e. STREET ADDRESS (If rural, give location) 2660 5084 Minerva	
3. NAME OF DECEASED (Type or Print) a. (First) William b. (Middle) Robert c. (Last) Gates		4. DATE OF DEATH (Month) (Day) (Year) 6 17 57	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 12-7-'74
9. AGE (In years last birthday) 82		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	11. BIRTHPLACE (City and State or Foreign Country) Mississippi
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME James Gates	
14. MOTHER'S MAIDEN NAME Josephine Jackson		15. NAME OF HUSBAND OR WIFE Mandie Gates	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Year or unknown) No (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. None	
18. INFORMANT'S SIGNATURE OR NAME Ida Green		19. ADDRESS 5084 Minerva	

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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac disease		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Semility DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		434.3	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
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)	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 June 15, 1957, to June 17, 1957, that I last saw the deceased alive on June 15, 1957, and that death occurred at 2:30 P.M. from the causes and on the date stated above.

23a. SIGNATURE R.C. Haskell (Degree or title) M.D.	23b. ADDRESS 1303 N. Kings Highway	23c. DATE SIGNED 6-17-57
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 6-24-57	24c. NAME OF CEMETERY OR CREMATORY Washington Park
24d. LOCATION (City, town, or county) (State) 5500 Brown Rd. Mo.	25. FUNERAL DIRECTOR'S SIGNATURE Boyd Funeral Home ADDRESS 3704 Franklin	
DATE REC'D BY LOCAL REG. JUN 18 57	REGISTRAR'S SIGNATURE J. Carl Smith, M.D.	(Licensed Embalmer's Statement on Reverse Side)

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

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.....
Signature of Student Embalmer

Signed *W. Claude Gordon*

Licensed Embalmer No. *348*

P. O. Address *4575 Al*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.