

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-038725
STATE FILE NUMBER

FILED NOV 24 1958 Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 357

1. PLACE OF DEATH a. COUNTY Adair		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Adair	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kirksville		c. CITY OR TOWN Kirksville	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION C.N.H. #1		d. STREET ADDRESS (If outside, give location) 901 S. First	

3. NAME OF DECEASED (Type or print) William Ellis Gates			4. DATE OF DEATH Month Nov. Day 13, Year 1958		
----------------------------------------------------------------------	--	--	-----------------------------------------------------------------------	--	--

5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 24, 1881	9. AGE (In years last birthday) 77	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
--------------------	------------------------------	--------------------------------------------------------------------------------------------------------------------------------------------------	-------------------------------------------	----------------------------------------------	-------------------------------------------	--------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Miner	10b. KIND OF BUSINESS OR INDUSTRY Coal Mine	11. BIRTHPLACE (City and state or country) Marceline, Mo.	12. CITIZEN OF WHAT COUNTRY? U. S. A.
---------------------------------------------------------------------------------------------------------------------	-------------------------------------------------------	---------------------------------------------------------------------	-------------------------------------------------

13a. FATHER'S NAME Simon Gates	13b. MOTHER'S MAIDEN NAME Jennie Ponteau	14. NAME OF HUSBAND OR WIFE Mayme Marshall
------------------------------------------	----------------------------------------------------	------------------------------------------------------

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) (If yes, give year or dates of service) No	16. SOCIAL SECURITY NO. 495-10-7761	17. INFORMANT Mrs. Mayme Gates, Kirksville, Mo.
------------------------------------------------------------------------------------------------------------------------	-----------------------------------------------	-----------------------------------------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cachexia of debilitation		INTERVAL BETWEEN ONSET AND DEATH weeks months unknown
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Cerebral Encephalomalacia	
	DUE TO (c) Cerebral Arteriosclerosis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 332 X		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
-----------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------

20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION Kirksville, Mo.	COUNTY Adair	STATE Mo.
--------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------	--------------------------------------------------------	------------------------	---------------------

21. I attended the deceased from **10-23-57** to **Nov 13, 1958** and last saw him alive on **11-12-58**
Death occurred at **4:05** A. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE George H. Scherer, D.O.	(Degree or title) 2	22b. ADDRESS Kirksville, Mo.	22c. DATE SIGNED 11-14-58
--------------------------------------------------	-------------------------------	----------------------------------------	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 11/15/58	23c. NAME OF CEMETERY OR CREMATORY Novinger Cemetery	23d. LOCATION (City, town, or county) (State) Novinger, Mo.
------------------------------------------------------------	------------------------------	----------------------------------------------------------------	-----------------------------------------------------------------------

24. FUNERAL DIRECTOR Paul M. Riley	ADDRESS Kirksville, Mo.	25. DATE RECD. BY LOCAL REG. 11-16-1958	26. REGISTRAR'S SIGNATURE Dora W. Gettiff
----------------------------------------------	-----------------------------------	---------------------------------------------------	-----------------------------------------------------

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 *Richard R. Ellis*

Licensed Embalmer No. *5036*

P. O. Address *Ferrisville, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.