

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=61-008783

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1161 STATE FILE NUMBER

AMENDED

FILED MAR 29 1961

1. PLACE OF DEATH
 a. COUNTY JACKSON
 b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City Length of stay in lb 6 Wks.
 c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION BLUERIDGE NURSING HOME Inside Limits Yes No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
 a. STATE KANSAS b. COUNTY MIAMI
 c. CITY OR TOWN LOUISBURG Inside Limits Yes No
 d. STREET ADDRESS (if outside, give location) Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First Middle Last EDGAR WAYNE GATES
 4. DATE OF DEATH Month Day Year 3 - 5 - 61
 5. SEX MALE
 6. COLOR OR RACE WHITE
 7. Married Never Married Widowed Divorced
 8. DATE OF BIRTH 12-20-23
 9. AGE (last birthday) 37
 IF UNDER 1 YEAR Months Days Hours Min.
 IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working-life, even if retired) NEVER EMPLOYED
 10b. KIND OF BUSINESS OR INDUSTRY -
 11. BIRTHPLACE (City and state or country) WICHITA-KANSAS
 12. CITIZEN OF WHAT COUNTRY U.S.A

13a. FATHER'S NAME HERBERT L. GATES
 13b. MOTHER'S MAIDEN NAME MARTHA MOREAN
 14. NAME OF HUSBAND OR WIFE NONE
 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO
 16. SOCIAL SECURITY NO. NONE
 17. INFORMANT Address MARTHA GATES. LOUISBURG, KA

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
 PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) Lymphosarcoma
 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____
 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____
 PART III. If deceased was female was there a pregnancy in last 90 days. Yes No Unknown
 INTERVAL BETWEEN ONSET AND DEATH 4 mo

19. WAS AUTOPSY PERFORMED? YES NO
 20a. ACCIDENT SUICIDE HOMICIDE
 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) _____
 20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____
 20d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK
 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____
 20f. CITY, TOWN, OR LOCATION _____ COUNTY _____ STATE _____

21. I attended the deceased from 1 January 1961 to 16 Feb 1961 and last saw her/him alive on 16 Feb 1961
 Death occurred at 7:30 am AM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) William E. Larsen MD
 22b. ADDRESS K.C. Kansas Kansas Univ Medical Center
 22c. DATE SIGNED 3-6-61
 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
 23b. DATE 3-8-61
 23c. NAME OF CEMETERY OR CREMATORY OLD MISSION
 23d. LOCATION (City, town, or county) (State) WICHITA SEDGWICK KAS
 24. FUNERAL DIRECTOR ADDRESS RUNYAN FUNERAL HOME LOUISBURG, MO
 25. DATE RECD. BY LOCAL REG. 3-6-61
 26. REGISTRAR'S SIGNATURE Ruth Long

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT

BY AFFIDAVIT OF WILLIAM E. LARSEN, M.D. MEDICAL CERTIFICATION

8292

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 Walter B. Runyan

Licensed Embalmer No. 3222

P. O. Address Louisburg, Kansas

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.