

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-020621

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 174 Primary Registration District No. 3035 Registrar's No. 50

FILED JUN 5 1963

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

1. PLACE OF DEATH a. COUNTY Lafayette			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Lafayette		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Lexington		Length of stay in 1b Over 60 yr	c. CITY OR TOWN Lexington		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Tevis Bridge Pl.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Tevis Bridge Pl.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) DELIA BATES			4. DATE OF DEATH Month May Day 27 Year 1963		
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. AMENDED BIRTH 25 1884	9. AGE (last birthday) 79	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physicians Office Assistant		10b. KIND OF BUSINESS OR INDUSTRY Doctor's Office	11. BIRTHPLACE (City and state or country) Bates City, Mo.	12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Ferdinand T. Bates		13b. MOTHER'S MAIDEN NAME Sarah Frances Cheatham		14. NAME OF HUSBAND OR WIFE Never Married	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, No, or unknown) (If yes, give No or dates of service) No		16. SOCIAL SECURITY NO. 190	17. INFORMANT Address Miss Lelia Bates Lexington, 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) Acute coronary thrombosis					INTERVAL BETWEEN ONSET AND DEATH 3 months
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. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	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 11:59 a.m. p.m. Month, Day, Year 12-15-53		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY
21. I attended the deceased from 12-15-53 to 5-27-63 and last saw her alive on 5-27, 63		Death occurred at 11:59 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Ben H Brasher M.D.		22b. ADDRESS Lexington, Missouri		22c. DATE SIGNED 5, 28, 63	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 5-30-63	23c. NAME OF CEMETERY OR CREMATORY Machpelah Cemetery	23d. LOCATION (City, town, or county) Lexington, Missouri		
24. FUNERAL DIRECTOR Vaughn Walker		ADDRESS Lexington, Mo.	25. DATE RECD. BY LOCAL REG. 5-29-63	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

USE BLACK INK
OR
TYPEWRITER RIBBON

(Licensed Embalmer's Statement on Reverse Side)

NOV 19 1961

STATE OF MISSISSIPPI

Handwritten notes on the right margin, including the name "Harold L. Walker" and other illegible text.

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 Harold L. Walker

Licensed Embalmer No. 4588

P. O. Address Lexington, 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.