

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

0050998

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 13089 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318  
**FILED JAN 9 1964**

VS 300	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	DATE AMENDED	INSTEAD OF	DOCUMENT
Rev. 4/59				
1				
2 <u>206</u>				
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4 <u>2</u>				
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12 <u>922</u>				
13				
<u>91</u>	SHOULD READ	BY AFFIDAVIT OF		

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		c. CITY OR TOWN <u>St. Louis</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>DOA Homer G. Phillips</u>		d. STREET ADDRESS (If outside, give location) <u>5577 Hebert Ave.,</u>	
3. NAME OF DECEASED (Type or print) <u>ELIJAH GATES</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>29</u> Year <u>1963</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>4-1-1938</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Porter</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and state or country) <u>Yazoo, Mississippi</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Robert Gates</u>		13b. MOTHER'S MAIDEN NAME <u>Rebecca Sanders</u>	
14. NAME OF HUSBAND OR WIFE <u>Wilma Gates</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) <u>No</u>	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Wilma J. Gates</u> Address <u>5577 Hebert Ave.,</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Traumatic Intra Cranial Hemorrhage, Cerebr;</u> <u>fractured skull, suffered when car operated by deceased struck</u> <u>Car, traffic signal and fire plug in vicinity of Hall Bridge</u> <u>and Union about 11:20 P.M. December 29<sup>th</sup> 1963.</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Remainder of conditions on part of Deceased</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
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. <u>816.4 - 226</u> <input type="checkbox"/> Yes <input 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.) <u>See above</u>	
20c. TIME OF INJURY Hour <u>11:20</u> a.m. / p.m. Month, Day, Year <u>12-29-63</u>		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.) <u>Street</u>		20f. CITY, TOWN, OR LOCATION <u>St Louis, MO</u>	
21. I attended the deceased from <u>11:40</u> to <u>11:40</u> and last saw her/him alive on <u>11-29-63</u> Death occurred at <u>11:40</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Helen L. Taylor, Coroner</u>		22b. ADDRESS <u>1300 Clark Ave.</u>	
22c. DATE SIGNED <u>1-2-64</u>		23. NAME OF CEMETERY OR CREMATORY <u>Canton, Miss.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>1-2-64</u>	
24. FUNERAL DIRECTOR <u>G. Wade Granberry</u>		25. DATE RECD. BY LOCAL REG. <u>JAN 2 1964</u>	
26. REGISTRAR'S SIGNATURE <u>Good Smith, M.D.</u>		27. ADDRESS	

USE BLACK INK OR TYPEWRITER RIBBON

**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 Edward A. F. Lynn

Licensed Embalmer No. 4444

P. O. Address 4202 Frimyard

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.