

FILED APR 7 1945

Registration District No. _____ Primary Registration District No. **3012**

1. PLACE OF DEATH:

(a) County Clay

(b) City or town Excelsior Springs
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Clay **24**

(c) City or town Excelsior Springs **1**
(If outside city or town limits, write "RURAL")

(d) Street No. 417 E. Broadway **1**
(If rural, give location)

(e) Citizen of foreign country? No **0** (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Allen Miller Bates

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Etta 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased June 12 1870
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>74</u>	<u>8</u>	<u>27</u>	hr. _____ min. _____

9. Birthplace Clay Co. Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Real Estate Salesman

11. Industry or business _____

MOTHER FATHER

12. Name Chas. F. Bates

13. Birthplace Ray Co. Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Anna Elizabeth Miller

15. Birthplace Ray Co. Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Ronnie Bates
(b) Address Kansas City, Missouri

17. (a) Burial (b) Date thereof 3/13/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Masonic Cemetery

18. (a) Signature of funeral director Chas. Pichard
(b) Address Excelsior Springs, Missouri

19. (a) 3-13-45 Mrs. Sadie Redman
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 9 year 1945 hour 5 minute _____ M.

21. I hereby certify that I attended the deceased from March 9th to 9th 1945 that I last saw him alive on 9th 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Acute coronary occlusion 20-min

Due to Arterio sclerosis

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

PHYSICIAN

Major findings: Of operations _____ Of autopsy 940

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature E. C. Robinson (M. D. or other) D. J. W.
Address Excelsior Springs Date signed 3/13/45

1166

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

RECEIVED

District Health Officer No. 8

District File Number

Date Filed

4/6/43

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 _____ Registered Apprentice No. _____ working under my personal supervision.

Signed

Earl Kapp

Licensed Embalmer No.

23458

P. O. Address

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