

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-032122

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 297 Primary Registration District No. 6022 Registrar's No. 93

DO NOT WRITE ON THIS STUB

AMENDED

FILED AUG 21 1962

1. PLACE OF DEATH a. COUNTY <u>RAY</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>RAY</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>RICHMOND TOWNSHIP</u>		c. CITY OR TOWN <u>RICHMOND</u>	
Length of stay in 1b <u>2 da</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>RAY COUNTY MEMORIAL HOSP.</u>		d. STREET ADDRESS (If outside, give location) <u>108 S. SHAW</u>	
Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>OTTO</u> Middle <u>-</u> Last <u>CATES</u>			4. DATE OF DEATH Month <u>AUGUST</u> Day <u>11</u> Year <u>1962</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>6/26/1888</u>	9. AGE (last birthday) <u>74</u>	IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GENERAL FARMING</u>		11. BIRTHPLACE (City and state or country) <u>RAY COUNTY, MISSOURI</u>	
12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>		13a. FATHER'S NAME <u>QUINT CATES</u>		13b. MOTHER'S MAIDEN NAME <u>AMANDA JEFFERS</u>	
14. NAME OF HUSBAND OR WIFE <u>1ST. ELIZABETH O DELL - DEC.</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>492-14-5591</u>	
17. INFORMANT <u>EUGRETT CATES, INDEPENDENCE, Mo.</u>		18. NAME OF HUSBAND OR WIFE <u>2ND. MAGGIE SLOAN - DIVORCED</u>		Address <u>14600 E. 40TH.</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) Myocardial infarction

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

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 _____ a.m. _____ p.m. _____ Month, Day, Year _____		

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 <u>Richmond, Mo.</u>	COUNTY _____ STATE _____
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21. I attended the deceased from _____ to _____ and last saw him alive on Aug 11, 1962
Death occurred at 8:15 A. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE J. D. Crozier, M.D. (Degree or title) 22b. ADDRESS Richmond, Mo. 22c. DATE SIGNED 8-13-62

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE AUG. 13, 1962 23c. NAME OF CEMETERY OR CREMATORY OLD NEW GARDEN CEMETERY 23d. LOCATION (City, town, or county) (State) 3 MI. E. OF EXCELSIOR SPRINGS, Mo.

24. FUNERAL DIRECTOR QUEST-LIFE FUNERAL HOME, RICHMOND, Mo. ADDRESS _____ 25. DATE RECD. BY LOCAL REG. 8-19-1962 26. REGISTRAR'S SIGNATURE Mabel Jackson

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK OR TYPEWRITER RIBBON

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS 300 Rev. 4/59
10890
2891
3
4 0
5 3
6
7 0
8 2
94201
10
11
121-0
132-0

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 Robert Thurman

Licensed Embalmer No. 4563

P. O. Address Richmond, 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.

no record of deceased