

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

REV. 3-1-35 I 19511

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

3537

FEB 24 1940 750

State File No. _____

Registration District No. 750

Primary Registration District No. 5985

Registrar's No. 1663

1. PLACE OF DEATH:

(a) County Ripley
 (b) City or town Ripley
 (c) Name of hospital or institution: Rural 2
 (If outside city or town limits, write "RURAL" and name of township)
 (d) Length of stay: In hospital or institution _____
 In this community 30 years.
 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Ripley
 (c) City or town Rural
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Alice Cates 32

3. (b) If veteran, name war ✓ 3. (c) Social Security No. ✓

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced married
 6. (b) Name of husband or wife Julian Cates 6. (c) Age of husband or wife if alive 25 years
 7. Birth date of deceased Oct 25 1883.
 (Month) (Day) (Year)

8. AGE: Years 56 Months 3 Days 15 If less than one day hr. ✓ min.

9. Birthplace Kentucky
 (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name Templeton
 13. Birthplace Kentucky
 (City, town, or county) (State or foreign country)
 14. Maiden name unknown
 15. Birthplace Ky.
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Julian Cates

(b) Address Douglas, Mo

17. (a) Burial (b) Date thereof 2-11-40
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Popes Chapel

18. (a) Signature of funeral director Franklin

(b) Address _____

19. (a) 2-11-1940 (b) C. B. Johnson
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 10
 year 1940 hour 6: minute A. M.
 21. I hereby certify that I attended the deceased from February 9
1940 to Feb. 10 1940
 that I last saw her alive on February 9 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death meningitis
 Due to Middle ear abscess
 Due to Flu.

Other conditions (include pregnancy within 3 months of death) 11/13

Major findings: Of operations _____
 Of autopsy _____
 PHYSICIAN _____
 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 J. Williams (M. D. or other) 1
 Address Douglas, Mo Date signed 2-10-40

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.....

Licensed Embalmer No.....

P. O. Address.....

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, above space should be left blank.