

S. No. 2
DM-5-42
v. 5-17-39
I X32B73

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

41183

FILED DEC 21 1945 **STANDARD CERTIFICATE OF DEATH**

State File No. _____

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 986

39
2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Greene

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

(c) Name of hospital or institution: St. John's Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)

In this community _____
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Greene 39

(c) City or town Springfield 2
(If outside city or town limits, write "RURAL")

(d) Street No. 2135 Travis 6
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME Cecil Owen Cates

3. (b) If veteran, name war no

3. (c) Social Security No. UNK.

4. Sex Male 0 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Veda M. Cates 6. (c) Age of husband or wife if alive UNK. years

7. Birth date of deceased Dec. 13, 1913
(Month) (Day) (Year)

8. AGE: Years 31 Months 11 Days 19 If less than one day no hr. _____ min. _____

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

10. Usual occupation Locomotive Fireman

11. Industry or business Frisco R. R. Co.

MOTHER FATHER { 12. Name Milton Cates

13. Birthplace Webster Co. Mo. 0
(City, town, or county) (State or foreign country)

14. Maiden name Edna Epps.

15. Birthplace Kansas City, Mo. 0
(City, town, or county) (State or foreign country)

16. (a) Informant Veda M. Cates

(b) Address 2135 Travis, Springfield Mo.

17. (a) Burial (b) Date thereof Dec. 4, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn Cem.

18. (a) Signature of funeral director J. W. Klingner

(b) Address Springfield Mo.

19. (a) 12-4-45 (b) D. W. Handley
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December Day 2, year 1945 hour 3 minute 15 P. A. M.

21. I hereby certify that I attended the deceased from Dec 1, 1945 to Dec 2, 1945; that I last saw h. 19 alive on Dec 2, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Meningitis

Duration 2 1/2 days

Due to _____

Due to _____

Other conditions 6
(Include pregnancy within 3 months of death)

PHYSICIAN _____

Major findings: _____

Of operations _____

Of autopsy _____

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)

Means of injury _____

23. Signature Max [unclear] (M. D. or other) MD.

Address Springfield Mo. Date signed 12-3-45

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NEG 27 1985

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, fact should be so stated above.

X