

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

State File No. ....

FILED JAN 26 1956

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. <b>532</b>			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Mo.</b> b. COUNTY _____					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (In this place) <b>1 yr.</b>		c. CITY OR TOWN <b>St. Louis</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>St. Louis Chronic Hosp.</b>				e. STREET ADDRESS (If rural, give location) <b>5800 Arsenal St.</b>					
3. NAME OF DECEASED (Type or Print) a. (First) <b>Dr. Lowrin Noah Cates D.D.S.</b>		b. (Middle) _____		c. (Last) _____		4. DATE OF DEATH (Month) (Day) (Year) <b>1-11-56</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Div.</b>		8. DATE OF BIRTH <b>2-19-1873</b>			
9. AGE (In years last birthday) <b>82</b>		IF UNDER 1 YEAR Months _____		IF UNDER 1 YEAR Days _____		IF UNDER 1 HR. Hours _____ Mins. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____		10b. KIND OF BUSINESS OR INDUSTRY <b>Dentist</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Indiana</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13a. FATHER'S NAME <b>John H.</b>		13b. MOTHER'S MAIDEN NAME <b>Jenivore ?</b>		14. NAME OF HUSBAND OR WIFE <b>Mildred Colby</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Hospital Records</b>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Anterior chestic Heart Disease</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Chronic Brain Syndrome due to Central Anterior lesion</b>				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <b>420.0</b>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____					
22. I hereby certify that I attended the deceased from <b>1-6-55</b> , 19____, to <b>1-11-56</b> , 19____, that I last saw the deceased alive on <b>1-11-56</b> , 19____, and that death occurred at <b>6:00 am.</b> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <b>George M. Tanaka, M.D.</b>				23b. ADDRESS <b>5600 Arsenal St.</b>		23c. DATE SIGNED <b>Jan 13, 1956</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>cremation</b>		24b. DATE <b>1-17-56</b>		24c. NAME OF CEMETERY OR CREMATORY <b>City Crematory</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis, Missouri</b>			
DATE REC'D BY LOCAL REG. <b>JAN 16 1956</b>		REGISTRAR'S SIGNATURE <b>Carl Smith M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>J. Ryan</b>		ADDRESS <b>5600 Arsenal St.</b>			

(Licensed Embalmer's Statement on Reverse Side)

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

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**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..

**NOT EMBALMED      CREMATED BY CITY.**

Student.....  
Signature of Student Embalmer

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.**  
**If this body is not embalmed, fact should be so stated above.**