

**FRI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH**

**59-028380**

**FILED VS AUG 31 1959** **53**

**3010**

**301**

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

INDEXED

1. PLACE OF DEATH a. COUNTY <u>Cape Girardeau</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>Union</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Cape Girardeau</u>		Length of stay in 1b <u>2 Days</u>		c. CITY OR TOWN <u>Anna</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>St. Francis Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>502 E. Vienna Street</u>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First: <u>Emery</u> Middle: <u>George</u> Last: <u>Cates</u>			4. DATE OF DEATH Month: _____ Day: <u>23</u> Year: <u>1959</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>2/22/1907</u>	9. AGE (last birthday) <u>52</u>	IF UNDER 1 YEAR Months: _____ Days: _____ Hours: _____ Min: _____	IF UNDER 24 HR Hours: _____ Min: _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Motel Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cates Motel</u>		11. BIRTHPLACE (City and state or country) <u>Cobden, Illinois</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Ernest Cates</u>			13b. MOTHER'S MAIDEN NAME <u>Millie Anderson</u>		14. NAME OF HUSBAND OR WIFE <u>Helen Cates</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes WW 2</u>			16. SOCIAL SECURITY NO. <u>344-01-5686</u>	17. INFORMANT <u>Helen Cates</u>		Address <u>Anna, Illinois</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) <u>Myocardial Infarction</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 da</u>	
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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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		COUNTY	STATE
21. I attended the deceased from <u>9-27-56</u> to <u>8/23/59</u> and last saw him alive on <u>8/23/59</u> Death occurred at <u>7:25 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Harold Redrup MD</u>			22b. ADDRESS <u>Cape Girardeau, Mo.</u>			22c. DATE SIGNED <u>8/24/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8/25/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Anna Cemetery</u>		23d. LOCATION (City, town, or county) <u>Anna Illinois</u>			
24. FUNERAL DIRECTOR <u>Hall R. McT...</u>			ADDRESS <u>Anna, Illinois</u>	25. DATE RECD. BY LOCAL REG. <u>8-27-59</u>	26. REGISTRAR'S SIGNATURE <u>Drene Kasten</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SEP 1 1959

NOV 18 1959

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*Hal R. McCarty*

Licensed Embalmer No. Ill. 8292

P. O. Address Anna, Illinois

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.