

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

SEP 25 1935

26467

1. PLACE OF DEATH

County Jackson Registration District No. 399
 Township Kaw Primary Registration District No. 1002
 City Kansas City (No. Menorah Hospital) St. _____ Ward _____

File No. 3244
 Registered No. _____

2. FULL NAME George David Cates

(a) Residence, No. 3800 McGee St. _____ Ward _____
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Lela Elizabeth Cates
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) August 12, 1876

21. DATE OF DEATH (MONTH, DAY, AND YEAR) August 12, 1935
 22. I HEREBY CERTIFY, That I attended deceased from March 19, 1935 to Aug 12, 1935
 I last saw him alive on Aug 12, 1935 Death is said to have occurred on the date stated above, at P. 9:20
 The principal cause of death and related causes of importance were as follows:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.
59 6 3
 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Commissioner Board of Election
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

Capsuloma of croup and tracheitis
 Other contributory causes of importance: 4%
Pneumo-pneumonia
 Name of operation Radu seeds Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? Yes

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Austin Texas
 13. NAME James M. Cates
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tennessee

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. _____
 Manner of injury _____
 Nature of injury _____

15. MAIDEN NAME Minerva Means
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois
 17. INFORMANT (ADDRESS) Mrs. Lela F. Cates, 3800 McGee St.

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____
 (Signed) Paul Spang, M. D.
 (Address) 440 W. 17th St.

18. BURIAL, CREMATION, OR REMOVAL PLACE Platte City Mo DATE August 14, 1935
 19. UNDERTAKER (ADDRESS) Stine & McQuinn, 323 1/2 Gillman Plaza
 20. FILED 8/14 1935 M. M. Crouse Registrar.

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.

WHITE PAPER, WITH IMPROVED INK—THIS IS A PERMANENT RECORD

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