

FILED SEP 19 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

29303

State File No. ....

No. 300  
10-48

BIRTH. NO. \_\_\_\_\_ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 958

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, reacklon before admission.) a. STATE <u>Mo.</u> b. COUNTY <u>Linn</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Marceline</u>	
c. LENGTH OF STAY (In this place) <u>3 1/2 yrs 3-7</u>		d. STREET ADDRESS (If rural, give location) <u>none</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>State Hospital No 2</u>			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>W</u>	b. (Middle) <u>Ruce</u>	c. (Last) <u>Cater</u>	4. DATE OF DEATH (Month) (Day) (Year)	<u>Sept.</u> <u>3</u> <u>49</u>
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5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Jan 3 1883</u>	9. AGE (In years last birthday) <u>66</u>	if UNDER 1 YEAR Days <u>8</u>	if UNDER 24 Hrs. Hours <u>0</u>	if UNDER 45 Min. <u>0</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Druggist</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Drug</u>	11. BIRTHPLACE (State or foreign country) <u>Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>US</u>
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13a. FATHER'S NAME <u>William Able Cater</u>	13b. MOTHER'S MAIDEN NAME <u>Eveline Nosen</u>	14. NAME OF HUSBAND OR WIFE <u>NONE</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Ruth Henryford</u>	ADDRESS <u>Marceline Mo</u>
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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		INTERVAL BETWEEN ONSET AND DEATH  <u>331X</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arterio Sclerosis</u> DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from Aug 1, 1949, to Sept 3, 1949, that I last saw the deceased alive on Sept 3, 1949, and that death occurred at 2:10 P. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Forrest Thomas M.D.</u>	23b. ADDRESS <u>St. Joseph Mo of State Hosp # 2</u>	23c. DATE SIGNED <u>9/3-49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>Sept. 3, 1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Marceline Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Marceline, Mo.</u>
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DATE REC'D BY LOCAL REG. <u>Sept. 7, 1949</u>	REGISTRAR'S SIGNATURE <u>E. B. Jenkins</u>	382	25. FUNERAL DIRECTOR'S SIGNATURE <u>O. Hermans W. Silenpader</u>	ADDRESS <u>1802 Union</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

NOV 10 1949

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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.

Signed Chas Thomas

Signed.....  
Student Embalmer

Licensed Embalmer No. 2640

P. O. Address St Joseph Mo

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.