

FILED JUN 4 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 16168
Registrar's No. 480

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000

0396
1

Dells

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

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Greene	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1063 E. Thoman		e. STREET ADDRESS 1063 E. Thoman	

3. NAME OF DECEASED (Type or Print) a. (First) EDWIN b. (Middle) E. c. (Last) CATES			4. DATE OF DEATH (Month) (Day) (Year) May 29 1951		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Dec. 2 1895	9. AGE (In years) last birthday 55	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY Colonial Hotel		11. BIRTHPLACE (State or foreign country) Missouri	
12. CITIZEN OF WHAT COUNTRY? USA					

13a. FATHER'S NAME Wm. R. Cates		13b. MOTHER'S MAIDEN NAME Lucindia Gains		14. NAME OF HUSBAND OR WIFE Deceased	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 491-05-1695		17. INFORMANT'S SIGNATURE OR NAME Mr. Lee Cates	
				ADDRESS Salem Missouri	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION metastatic IntraCRANIAL Neoplasm -			INTERVAL BETWEEN ONSET AND DEATH 6 mo
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		DUE TO (b) prob. Carcinoma of lung			?
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		DUE TO (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		162x			

19a. DATE OF OPERATION ?		19b. MAJOR FINDINGS OF OPERATION intraCRANIAL metastatic Ca - let temporal lobe			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)		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 March, 1951, to May, 1951, that I last saw the deceased alive on April, 1951, and that death occurred at 8:45 a. m., from the causes and on the date stated above.

23a. SIGNATURE Joseph N. Hicks M.D.		23b. ADDRESS Springfield, Mo		23c. DATE SIGNED 5-31-51	
24a. BURIAL CREMATION, REMOVAL (Specify) Burial		24b. DATE May 31, 1951		24c. NAME OF CEMETERY OR CREMATORY East Lawn Cemetery	
				24d. LOCATION (City, town, or county) (State) Springfield, Missouri	
DATE REC'D BY LOCAL REG. 5-31-51		REGISTRAR'S SIGNATURE W.E. Handley		25. FUNERAL DIRECTOR'S SIGNATURE J. W. Klingner & Co.	
				ADDRESS Springfield	

JUN 16 1951

JUN

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.....

working under my personal supervision.

Student Embalmer No.....



Signed.....
Student Embalmer

Signed *William D. Cantrell*.....

Licensed Embalmer No. *4820*.....

P. O. Address *Spring Hill, 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.