LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

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

27758

PLACE OF DEATH

County Montgomery — Registration District No. 595 — File No. 47

Township — Primary Registration District No. 4853 — Registered No. 147

City Wellsville (No. ..... St. ..... Ward)

FULL NAME Rosabel Tate

(a) Residence. No. ..... St., ... Ward. ..... (If nonresident give city or town and State)
(Usual place of abode)

th 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

EX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
male	white	married

F MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF (OR) WIFE OF R. J. Tate

ATE OF BIRTH (MONTH, DAY AND YEAR) June 14 - 1882

GE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or [redacted]
	40	3	1	

CCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer) Same
(c) Name of employer

RTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Calloway Co Mo

0. NAME OF FATHER Alfred Windsor

1. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Montgomery Co Mo

2. MAIDEN NAME OF MOTHER Sara Ellen Biers

3. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Calloway Co Mo

INFORMANT R. J. Tate
(Address) Wellsville Mo

FILED Sept 20 1923 — W E Prewitt, REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept - 13 - 1923

17. I HEREBY CERTIFY, That I attended deceased from Sept - 14, 1923, to Sept - 15, 1923 that I last saw her alive on Sept 15, 1923 and that death occurred, on the date stated above, at 4 45 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

[redacted] Eclampsia m. Puerperal

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Fibroid Interstitial

..... (duration) 1 yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED at home

IF NOT AT PLACE OF DEATH? 147

DID AN OPERATION PRECEDE DEATH? no. DATE OF .....

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) J A Bellamy, M. D

, 19 (Address) Wellsville Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Pat Grove (Calloway Co)	9 - 17 1923

20. UNDERTAKER R B Wells — ADDRESS Wellsville Mo

LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

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

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No.....; .....St. .....W

2. FULL NAME .....

(a) Residence. No.....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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or .....min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY)

14.
INFORMANT .....
(Address)

15.
FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

17.
I HEREBY CERTIFY, That I attended deceased from .....
.....,19....., to .....,
that I last saw h..... alive on.....,19....,
death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

.....(duration).....yrs. .....mos.

CONTRIBUTORY.....
(SECONDARY)

.....(duration).....yrs. .....mos.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?.....
DID AN OPERATION PRECEDE DEATH?..... DATE OF.....
WAS THERE AN AUTOPSY?.....
WHAT TEST CONFIRMED DIAGNOSIS?.....
(Signed).....
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL

20. UNDERTAKER	ADDRESS