

JUN 27 1927

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

Do not use this space.

14866

1. PLACE OF DEATH *Henry*
County.....*Henry* Registration District No. *347*
Township..... Primary Registration District No. *3018*
City *Clinton Mo* (No.) St. Ward)
2. FULL NAME *Dora Tate*
(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. da. How long in U.S., if of foreign birth? yrs. mos. da.

File No.
Registered No. *65*
St. Ward)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Divorced*
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Francis Tate*
6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Apr. 20, 1894*
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
33 1 6
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work *House keeper*
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) *Cedar Co Mo*
(STATE OR COUNTRY)
10. NAME OF FATHER *John G. Hudson*
11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Cedar Co Mo*
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER *Paula G Meach*
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *Barren Co Tennessee*
(STATE OR COUNTRY)

14. INFORMANT *J. G. Hudson*
(Address) *J. G. Decker Mo*
15. FILED *5/27 1927* *Dr. E. C. Peelor*
by J. J. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *May 26 1927*
17. I HEREBY CERTIFY, That I attended deceased from *May 15 1927* to *May 26 1927*, and that I last saw *her* alive on *May 26 1927*, and that death occurred, on the date stated above, at *2 P. M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:
44a
Causes of stomach
(duration) ... yrs. ... mos. ... da.

CONTRIBUTORY (SECONDARY) (duration) ... yrs. ... mos. ... da.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH... *Henry Co Mo*
19. DID AN OPERATION PRECEDE DEATH? *No* DATE OF ...
WAS THERE AN AUTOPSY? *No*
WHAT TEST CONFIRMED DIAGNOSIS? *Clinical*
(Signed) *W. J. Stillman*, M. D.
, 19 (Address)

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *Deerpark Mo* DATE OF BURIAL *5/27 1927*
20. UNDERTAKER *Tom Hurst* ADDRESS *Deerpark Mo*

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.

