

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

Do not use this space.

24910-a
File No. _____
Registered No. _____
St. _____ Ward _____

1928

PLACE OF DEATH

County Miller
Township Equality
City _____

Registration District No. 564
Primary Registration District No. 575

2. FULL NAME J N 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.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 3-26-1853

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
72 4 15

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(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) MO

10. NAME OF FATHER XX

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

12. MAIDEN NAME OF MOTHER XX

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

14. INFORMANT Chas Hadden (Address) Olden

15. FILED _____, 19 _____ REGISTRAR _____

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8/17 1927

17. I HEREBY CERTIFY, That I attended deceased from Aug 11, 1927 to Aug 11, 1927 that I last saw him alive on Aug 5, 1927, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Broncho Pneumonia
18713
1000 (duration) yrs. mos. da.

CONTRIBUTORY Chronic Bronchitis (SECONDARY) (duration) 17 yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH: _____

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

20. WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? clinical test
(Signed) E. L. S. Patton, M. D.
, 19 _____ (Address) Olden, 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Allen Cemetery DATE OF BURIAL 8/12 1927

20. UNDERTAKER W. A. Rutledge ADDRESS Olden

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.

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**MISSOURI STATE BOARD OF HEALTH
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ALL INFORMATION REQUESTED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH
 County Miller Registration District No. 364 File No.
 Township Equality Primary Registration District No. 3-73-8 Registered No.
 City Neosho St. Ward

2. FULL NAME S. N. 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 2 yrs. 0 mos. 0 da. How long in U.S., if of foreign birth? 2 yrs. 0 mos. 0 da.

PERSONAL AND STATISTICAL PARTICULARS

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

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 (duration) yrs. mos. da.
 (b) General nature of industry, business, or establishment in which employed (or employer) (duration) yrs. mos. da.
 (c) Name of employer

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

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT char g... 2nd (Address)

15. FILED 5/11/27 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8-11 1927

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

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

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)....., 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 DATE OF BURIAL 19

20. UNDERTAKER ADDRESS

N. B.—Every item of information should be carefully stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be readily classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHOULD NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

SUPPLEMENTARY

S-24910-A