

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

Do not use this space.

5333

1. PLACE OF DEATH

County *Atchison*
Township *Rockport*
City *Rockport*

Registration District No. *19*
Primary Registration District No. *4013*

File No.
Registered No.
St. Ward)

FULL NAME *Laura 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 *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Married*

5A. IF MARRIED, WIDOWED, OR DIVORCED
"HUSBAND OF" (OR) "WIFE OF" *Callie Tate*

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ... hrs. or ... min.
32

8. OCCUPATION 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)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) *Douglas Co.*
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER *Reley Kicks*

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

12. MAIDEN NAME OF MOTHER *Martha Reley*

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

14. INFORMANT *Callie Tate*
(Address) *Rockport Mo.*

15. FILED *3-1-1929* *Mary G. Chambers*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Feb 27 1929*

17. I HEREBY CERTIFY That I attended deceased from *Feb 27 1929* to *Feb 27 1929* and that I last saw her alive on *Feb 27 1929* and that death occurred, on the date stated above, at *11 P* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Lobar pneumonia

CONTRIBUTOR (SECONDARY) *1010*

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

(1) DID AN OPERATION PRECEDE DEATH? *no* DATE OF

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) *Shirley Little*, M. D.

*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.
Feb 28, 1929 (Address) Rockport Mo.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *Mountain Grove Mo.* DATE OF BURIAL *Mar 2 1929.*

20. UMBERTAKER *B. M. Sanders* ADDRESS *Rockport 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.

MAR 21 1929

...in plain terms, so that it may be understood that the exact nature of the OCCUPATION is very EXACTLY. PHYSICIANS ...

**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
 County Albion Registration District No. 19 File No.
 Township Rock Port Primary Registration District No. 4013 Registered No.
 City (No.) St. Ward)

2. FULL NAME Laura 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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 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 did not know

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
32 4 4

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)

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 27 1929

17. I HEREBY CERTIFY That I attended deceased from 19... 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:

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

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

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

SUPPLEMENTARY

REGISARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW
 Fully supplied. AGE should be stated EXACTLY. OCCUPATION should be properly classified. Exact statement of OCCUPATION is very important.

15. FILED....., 19..... Mary J. Chamberlain
 REGISTRAR

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