

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

Do not use this space.

JUN 12 1937

1. PLACE OF DEATH

County Jackson
Township Bay
City B. G. Mo.

Registration District No. 399
Primary Registration District No. 702
(No. 1509 E 10th 3rd. 7th)

File No. 19153
Registered No. _____
St. _____ Ward _____

2. FULL NAME

(a) Residence No. 1509 E 10th St., _____ Ward.

(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

MEDICAL CERTIFICATE OF DEATH

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov. 22 - 1936

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
5 27

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) Infant

11. Total time (years) spent in this occupation.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis City, Mo.

13. NAME Marion Tate

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis City, Mo.

15. MAIDEN NAME Alberta Tate

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis City, Mo.

17. INFORMANT (ADDRESS) Alberta Tate 1509 E 10th

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE Blue Ridge May 24 - 1937

19. UNDERTAKER (ADDRESS) Dayle Brown 1708 Francis

20. FILED May 24, 1937 M. M. Crowe, Reg.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-19-37, 1937

22. I HEREBY CERTIFY, That I attended deceased from 5-18-37, 19... to 5-19-37, 19... I last saw him alive on 5-19-37, 19... Death is said to have occurred on the date stated above, at 12.55 PM

The principal cause of death and related causes of importance were as follows:

Acute Bronchopneumonia
Acute Bronchopneumonia

Other contributory causes of importance: Obst.!

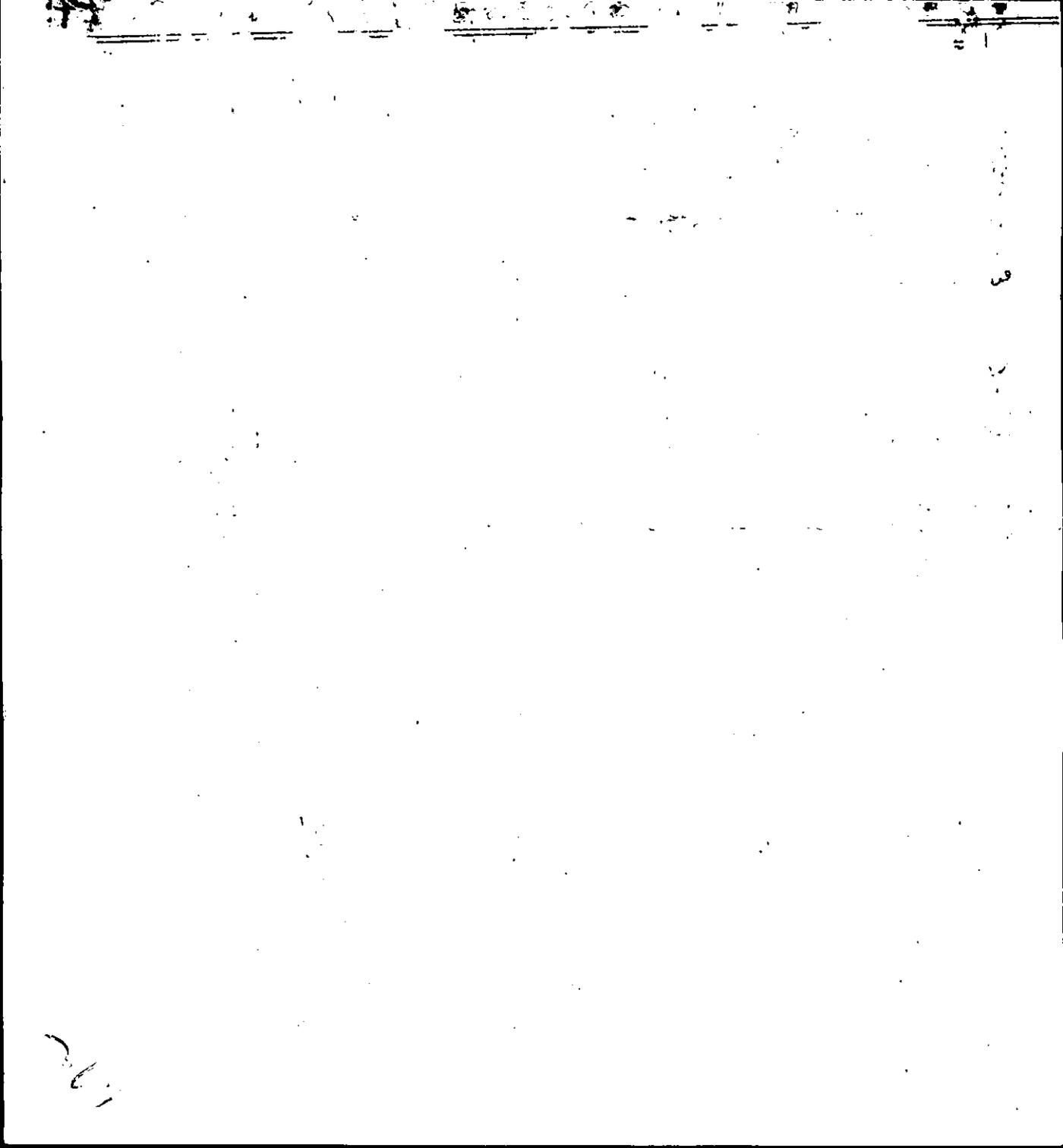
Name of operation None Date of _____
What test confirmed diagnosis Autopsy Was there an autopsy no

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? no Date of injury no, 19...
Where did injury occur? no (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place. no
Manner of injury no no no no
Nature of injury no no no no

24. Was disease or injury in any way related to occupation of deceased?
If so, specify no
(Signed) Alvin B. Bryant, M.D.
(Address) 1695 - 27th St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.



FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

19153
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1. PLACE OF DEATH

(a) County Jackson Registration District No. 399
(b) Township _____ Primary Registration District No. 1002
(c) City K.C. (d) Street No. _____ St. _____
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

Registered No. 2367

2. PRINT FULL NAME

John Jr. Tate
(a) Residence, No. _____ St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

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

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.
5 27

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

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

FATHER
13. NAME

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

MOTHER
15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____ 19____

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED _____ 19____

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-19 1937

22. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19____

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

acute Broncho Pneumonia
no complications
such as pleurisy, etc.
Other contributory causes of importance:
Obese

Date of onset

Name of operation none Date of _____
What test confirmed diagnosis clinical Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____

(Signed) Henry B. Lyons, M. D.
(Address) 1605 E. 8th St.

SUPPLEMENTARY

5-19153