

Registration District No. **547**

Primary Registration District No. **3029**

Registrar's No. **244**

1. PLACE OF DEATH:

(a) County Marion
(b) City or town Taylor Hannibal
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Elizabeth Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution five days
(Specify whether years, months or days) Five days

3. (a) PRINT FULL NAME Charles William Tate 3rd

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased September 24, 1926
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>13</u>	<u>11</u>	<u>25</u>	hr. _____ min.

9. Birthplace Marion County Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Student

11. Industry or business _____

12. Name William Earl Tate

13. Birthplace Marion County Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Elsie Slater

15. Birthplace Marion County Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Elsie Tate

(b) Address Taylor, Missouri

17. (a) Removal (b) Date thereof Aug 21, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hester, Missouri

18. (a) Signature of funeral director Ray P. Schwartz

(b) Address Hannibal, Missouri

19. (a) Aug 20, 1940 (b) W. A. Fisher
(Day received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Marion
(c) City or town Taylor
(If outside city or town limits, write "RURAL")
(d) Street No. Rural Route No. 1
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 19 year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from Aug 3 to Aug 19, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death Strep septicaemia
Due to Strep viridans

Due to _____

Other conditions (including pregnancy within 3 months of death) W. Shouler Enders

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work _____ (Specify type of place) (e) Means of injury _____

23. Signature W. A. Fisher (M. D. or other) _____

Address 1001 Brighton Date signed _____

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically

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.

9118

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

Roy P. Schwartz
working under my personal supervision.

Registered Apprentice No.....

Signed *Roy P. Schwartz*

Licensed Embalmer No. *1765*

P. O. Address *Hannibal, Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

Registration District No. **547**

Primary Registration District No. **3029**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County **Marion**
(b) City or town **Hannibal**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Charles Wm Tate**

3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex **m** 5. Color or race **w** 6. (a) Single, widowed, married, divorced **s**

6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive, year

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
13 11 25 hr. min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

MOTHER FATHER { 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name (City, town, or county) (State or foreign country)
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (b) Date thereof (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (b) (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County
(c) City or town (If outside city or town limits write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A. years

MEDICAL CERTIFICATION

20. DATE OF DEATH Month **Aug** day **19** year **1940** hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19; that I last saw him alive on 19; and that death occurred on that date and hour stated above.

Immediate cause of death **Strep Septicemia**
Strep viridans

Due to **Chronic Tonsillitis**

Other conditions (include pregnancy within 3 months of death) **Valvular Endo-Carditis**

Major findings: Of operations **g2w**
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury

23. Signature **J. H. [Signature]** (M. D. or other)
Address **105 [Address]** Date signed **11-5-40**

SUPPLEMENTAL

