

NOV 12 1940
Registration District No. _____

Primary Registration District No. **1002**

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

1. PLACE OF DEATH:
 (a) County **Jackson**
 (b) City or town **Kansas City Mo.**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
1625 Summitt Ave.
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether)
 In this community **55 Yrs.**
years, months or days

3. (a) PRINT FULL NAME **William J. TATE.**
 (b) If veteran, name war _____
 (c) Social Security No. **490-16-2222**

4. Sex **Male**
 5. Color or race **White**
 6. (a) Single, widowed, married, divorced **Widower**
 (b) Name of husband or wife **Ollie Tate**
 (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased **December 4th, 1863.**
(Month) (Day) (Year)

8. AGE: Years **76** Months **10** Days **23**
 If less than one day
 hr. _____ min.

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

10. Usual occupation **Watchman**

11. Industry or business **Thompson Transfer Co.**

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

16. (a) Informant **Mrs. Eva Holloway.**
 (b) Address **1625 Summitt.**

17. (a) **Burial** (b) Date thereof **10/29/40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Woodlawn K. C. K.**

18. (a) Signature of funeral director **Melody-McGilley.**

(b) Address **10-28-40 K. C. Mo.**

19. (a) _____ (b) **M. M. Crowe**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Jackson**
 (c) City or town **Kansas City Mo.**
(If outside city or town limits, write "RURAL")
 (d) Street No. **1625 Summitt Ave.**
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **October** day **27**
 year **1940** hour _____ minute **2** a.m.

21. I hereby certify that I attended the deceased from **Sept 1 -**
 _____, 19**40** to **Oct 27**, 19**40**;
 that I last saw him alive on **Oct 27**, 19**40**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Hemorrhage**
 Duration **3 days**

Due to _____

Due to **mental insufficiency**

Other conditions **92.0**
(Include pregnancy within 3 months of death)

PHYSICIAN
 Major findings:
 Of operations _____
 Of autopsy _____
 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: _____

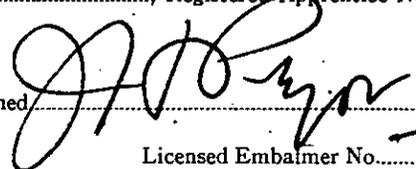
23. Signature **Paula Jackson** (M. D. or other) **Med.**
 Address **1103 E. Cannon** Date signed **11-28-40**

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.....

....., Registered Apprentice No. 267
working under my personal supervision.

Signed



Licensed Embalmer No. 2999

P. O. Address.....

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, fact should be so stated above.