

Registration District No. 12

Primary Registration District No. 5711

Registrar's No. 8

1. PLACE OF DEATH

(a) County Boone  
 (b) City or town Centralia Tpt  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: 1  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether)  
 In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME

Father Gentry Tate

3. (b) If veteran, name war ✓

3. (c) Social Security No. 500-09-9479

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Dora Francis Tate

6. (c) Age of husband or wife if alive 60 years

7. Birth date of deceased July 6 1881

(Month) (Day) (Year)

8. AGE:

Years

Months

Days

If less than one day

59 to 7 9

hr. min.

9. Birthplace Montgomery Co., MO

(City, town, or county) (State or foreign country)

10. Usual occupation PT. C.A. Worker

11. Industry or business

12. Name Warren Tate

Warren Tate

13. Birthplace 1 Ky

(City, town, or county) (State or foreign country)

14. Maiden name 1 Ky

1 Ky

15. Birthplace 1 Ky

(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Dora F Tate

Mrs Dora F Tate

(b) Address Mexico, Mo.

Mexico, Mo.

17. (a) Burial

(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Montgomery City, Mo

Montgomery City, Mo

18. (a) Signature of funeral director W. E. Ogden

W. E. Ogden

(b) Address Mexico, Mo

Mexico, Mo

19. (a) 7-15-1941

(Date received local registrar) (b) F. H. Borden, MD

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Andrew  
 (c) City or town Mexico  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 2  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A? 1 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 15 day 4 Feb year 1941 hour 12 minute 3.50 P.M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death: Leban's Interstitial myocarditis

Due to Arterio Sclerosis

Other conditions: Right Heart Failure  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
 Of operations \_\_\_\_\_

Of autopsy as above

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? 36

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

23. Signature Marion Madson  
(M.D. or other) 2  
 Address Columbia Mo Date signed 2/15/41

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

**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.....  
working under my personal supervision.

Signed T. E. Priddy  
Licensed Embalmer No. 3189  
P. O. Address Mexico, MS

**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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. 6255

Registration District No. 72

Primary Registration District No. 5111

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Boone  
(b) City or town Centralia T.P.  
(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 \_\_\_\_\_ (Specify whether  
In this community \_\_\_\_\_ years, months or days)

3. (a) PRINT FULL NAME Luther Gentry 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 W

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

7. Birth date of deceased July - 6 - 1881  
(Month) (Day) (Year)

8. AGE: Years 59 Months 6 Days 9 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 3/5/41 (b) J. H. Gardner (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: Audrain

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

20. DATE OF DEATH: Month Feb day 15 year \_\_\_\_\_ 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 the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

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 Marion Madans (M. D. or other) \_\_\_\_\_  
Address Columbia Mo Date signed \_\_\_\_\_

SUPPLEMENTAL

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

S-6255