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DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

FILED JAN 11 1943

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

2138

State File No.

Registration District No. 109

Primary Registration District No. 3019

Registrar's No.

1. PLACE OF DEATH: Remickal-Dunklin

(a) County Remickal  
(b) City or town Kennett  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution Kennett Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution  
In this community 2 days  
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED: Remickal

(a) State MO (b) County Remickal  
(c) City or town Kennett  
(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

3. (a) PRINT FULL NAME David Tate

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

4. Sex M 5. Color or Race Cal 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 3 28 1919  
(Month) (Day) (Year)

8. AGE: Years 23 Months 8 Days 28 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation laborer

11. Industry or business farm

12. Name David Tate

13. Birthplace Newton Co., Miss  
(City, town, or county) (State or foreign country)

14. Maiden name Mary Norman

15. Birthplace Newton Co., Miss  
(City, town, or county) (State or foreign country)

16. (a) Informant Ray Tate

(b) Address Wydatt MO

17. (a) Burial (b) Date thereof Nov. 21, 1942  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Remickal County farm

18. (a) Signature of funeral director Henry Raudolph

(b) Address Supt Remickal Co. farm

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 19  
year 1942 hour 5 minute 30 AM. M.

21. I hereby certify that I attended the deceased from 11-19-42  
19. to 11-19-42 19. ;

that I last saw him alive on 11-19-42 19. ;  
and that death occurred on the date and hour stated above.

Immediate cause of death Hemorrhage in abdominal cavity Duration 1 1/2 hr

Due to gunshot wound

Due to \_\_\_\_\_

Other conditions 1/6 hr  
(Include pregnancy within 3 months of death)

Major findings: Bullet hole through  
Of operations Scrupers, Colon, Small intestine, Spleen, Diaphragm, Left Side, Lower Lobe Left Lung, Spleen cut, Cornea, pleura, aorta

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 11-19-42 about 2 a.m.

(c) Where did injury occur? Home, Remickal, Miss  
(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 D. R. Linnell (M. D. or other) MD

Address 15 Kennett, Missouri Date signed 11-19-42

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

P

U.F. 1

1-27-43

STATE OF MISSISSIPPI

**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.....

Licensed Embalmer No.....

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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 107  
Registrar's No. 15

Registration District No. 107

Primary Registration District No. 3019

1. PLACE OF DEATH:

(a) County DeKalb  
(b) City or town Senett  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Kennell Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 hours  
(Specify whether  
In this community \_\_\_\_\_  
years, months or days)

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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME

David Tate

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 19  
year 1942 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him/her alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M 5. Color of race B 6. (a) Single, widowed, married, divorced \_\_\_\_\_

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

7. Birth date of deceased March 20 (Month) (Day) (Year)

8. AGE: Years 23 Months 7 Days 10 If less than one day \_\_\_\_\_ 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 \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

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

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

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

19. (a) 1-28-43 (b) Julia Blankenship  
(Date received local registrar) (Registrar's signature)

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)  
(b) Did injury occur in or about home, on farm, in industrial place, in public place?  
\_\_\_\_\_ (Specify type of place)  
While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other)

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

MOTHER FATHER

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

2136

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 41930

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County \_\_\_\_\_

(b) City or town \_\_\_\_\_  
(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 \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME David Tate

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

4. Sex m 5. Color or race B 6. (a) Single, widowed, married, divorced S

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

7. Birth date of deceased mar 20  
(Month) (Day) (Year)

8. AGE: Years 23 Months 7 Days 23 if less than one day \_\_\_\_\_ min.

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

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

(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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov Day 19 Year 1942 Hour \_\_\_\_\_ Minute \_\_\_\_\_ M.

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

Immediate cause of death hemorrhage in abdominal cavity

Due to gunshot wound

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) Homicide

(b) Date of occurrence 11-19-42

(c) Where did injury occur? State, Penna. 1940  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
Girl friend's home

While at work? 19 (Specify type of place) (e) Means of injury Gunshot

23. Signature H.R. Penner (M. D. or other) \_\_\_\_\_  
Address Penna. 1940 Date signed 2-1-43

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

SUPPLEMENTARY

MOTHER FATHER

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

2136

Kulshreshtha

18263