

FILED SEP 2 1943

Registration District No. 374

Primary Registration District No. 62-76455 D

Registrar's No.

1. PLACE OF DEATH:

- (a) County North
(b) City or town Sheridan, Mo.
(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

60 yrs.

3. (a) PRINT
FULL NAME

WILLIAM THOMAS TATE

3. (b) If veteran,
name war3. (c) Social Security
No.

4. Sex

M

5. Color or
race

W

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

Married

6. (b) Name of husband or wife

Lena Maude Tate

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

78 years

7. Birth date of deceased

June 23

1865

(Month)

(Day)

(Year)

8. AGE:

Years

Months

Days

If less than one day

78

0

19

hr.

min.

9. Birthplace

South Morgan County, West

(City, town, or county)

(State or foreign country)

10. Usual occupation

Retailer

11. Industry or business

Wholesale Groceries

12. Name

Thomas C. Tate

13. Birthplace

Yorkshire, England

(City, town, or county)

(State or foreign country)

14. Maiden name

Lena Maude Fleet

15. Birthplace

York, N.Y.

(City, town, or county)

(State or foreign country)

16. (a) Informant

Fred Tate

(b) Address

Sheridan, Mo.

17. (a)

(Burial, cremation, or removal)

(b) Date thereof

7-14-43

(Month) (Day) (Year)

(c) Place: burial or cremation

Sheridan, Mo.

18. (a) Signature of funeral director

Frank C. Duffee

(b) Address

Frank City, Mo.

19. (a)

(Date received local registrar)

(b)

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State

Mo.

(b) County

North

(c) City or town

Sheridan, Mo.

(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

0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month

July

day

12

year 1943

hour

11

minute

30 P.M.

21. I hereby certify that I attended the deceased from

May 2

1943 to

July 12, 1943

that I last saw him alive on

July 12

and that death occurred on the date and hour stated above.

Immediate cause of death

Myocarditis

Duration

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

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

(M. D. or other)

Address

Date signed

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

DEC 4 1946

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.....

Arch C. Dumble

Licensed Embalmer No. *3252*

P. O. Address *Grant City, 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, fact should be so stated above.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 29657
Registrar's No. _____

Registration District No. 374

Primary Registration District No. 4850

1. PLACE OF DEATH:

- (a) County North
(b) City or town Sheldon
(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 Wm Thomas 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 M

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

7. Birth date of deceased June 22 1900
(Month) (Day) (Year)

8. AGE: Years 78 Months _____ Days _____ If less than one day, _____ min.

9. Birthplace Canada
(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) Aug 3, 1943 (b) Arline Scadden
(Date received from 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 July day 2
year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____;
that I last saw him _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____ Duration _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

29657