

43366

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registrar's No. 122

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 12 1943

Registration District No. 275

Primary Registration District No. 3053

1. PLACE OF DEATH:

(a) County Phelps

(b) City or town Rolla

(c) Name of hospital or institution: McFarland Hospital
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Phelps

(c) City or town Edgar Springs
(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

3. (a) PRINT FULL NAME: James S. Tate

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

20. DATE OF DEATH: Month Dec. day 20
year 1943, hour _____ minute _____ P. M.

4. Sex W 5. Color or race W

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

6. (b) Name of husband or wife: Jewel Tate

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

7. Birth date of deceased: July 1 1882
Month (Day) (Year)

21. I hereby certify that I attended the deceased from Oct 29/43
1943 to Dec 20 1943

that I last saw him alive on 1:00 P.M. Dec 20, 1943
and that death occurred on the date and hour stated above.

8. AGE: Years _____ Months 5 Days 20
If less than one day _____ hr. _____ min.

Immediate cause of death Dislocation of the A. Artery Duration _____

9. Birthplace: Smith Plant, Colmo
(City, town, or county) (State or foreign country)

Due to Trauma

Due to _____

10. Usual occupation: Station Agent

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

11. Industry or business _____

MOTHER FATHER { 12. Name: Wm Tate

13. Birthplace: Rolla (City, town, or county) (State or foreign country)

14. Maiden name: Jewel Yarnall

15. Birthplace: Rolla (City, town, or county) (State or foreign country)

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant: Grace Green

(b) Address: Rolla Mo

17. (a) Rolla (b) Date thereof: 12/22/43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Rolla

18. (a) Signature of funeral director: Grace Green

(b) Address: Rolla Mo

19. (a) 12/22/43 (b) John Walker
(Date received local registrar) (Registrar's signature)

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: John Walker (M. D. or other) _____

Address _____ Date signed: 12/22/43

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

No. 2
11-10-39
5-17-39
X21492

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

Signed.....

Licensed Embalmer No. 3394

P. O. Address Rolla 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. *Jan.*

Registration District No. _____

Primary Registration District No. _____

Registrar's No. _____

1. PLACE OF DEATH

- (a) County *Polk*
- (b) City or town *Rolla*
- (c) Name of hospital or institution: *McFarland Hosp.*
(If not in hospital or institution, write street number or location)
- (d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)

In this community _____
years, months or days

3. (a) PRINT FULL NAME

James I. 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

July 1 1882
(Month) (Day) (Year)

8. AGE:

Years *61* Months *5* Days *20* If less than one day min. _____

9. Birthplace _____

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

13. Birthplace _____

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

14. Maiden name _____

15. Birthplace _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____
(Burial, cremation, or removal)

(b) Date thereof _____
(Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____
(Date received local registrar)

(b) _____
(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 *10* Year *1943* Hour _____ Minute _____ M. _____

21. I hereby certify that I attended the deceased from _____ 19____; _____ 19____;

that I last saw him alive on _____, 19____;

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

Immediate cause of death *dissection of the a. artery*

Due to *trauma*

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) *Accident*
- (b) Date of occurrence *Oct. 29, 1943*
- (c) Where did injury occur? *Home, Edgar Springs Mo.*
(City or town) (County) (State)
- (d) Did injury occur in or about home, on farm, in industrial place, in public place? *Home*

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

23. Signature _____ (D. or other) _____
Address *Rolla Mo.* Date signed *11/15/44*

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

SUPPLEMENTAL

INTENT

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

5-43366