

S. No. 2
M-542
v. 5-17-39
I X32873

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DEPARTMENT OF COMMERCE
BUREAU OF CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED DEC 31 1944

Registration District No. 378

Primary Registration District No. 6785

Registrar's No. 51

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

1. PLACE OF DEATH:

(a) County Wright
(b) City or town Wright
(c) Name of hospital or institution: None
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community Lifetime years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Wright
(c) City or town Mtn. Grove - Rural
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Lawrence Gardner Tate

3. (b) If veteran, name war No

3. (c) Social Security No. No

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 7th
year 1943 hour 5:30 minute A. M.

21. I hereby certify that I attended the deceased from 10/25 1943 to 11/6 1943
that I last saw him alive on 11/5-43 and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife Lydias McCall Tate 6. (c) Age of husband or wife if alive 53 years
7. Birth date of deceased December 23, 1888
(Month) (Day) (Year)

Immediate cause of death Cerebral Apoplexy

8. AGE: Years 54 Months 10 Days 14 If less than one day _____ hr. _____ min.

Due to _____
Due to _____

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

Other conditions (Include pregnancy within 3 months of death) 83a

10. Usual occupation Farmer

Major findings: Of operations _____
Of autopsy _____

11. Industry or business _____

12. Name Allen L. Tate

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

14. Maiden name Matie Murphree

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

16. (a) Informant Mrs. Lydia Tate

(b) Address Mtn. Grove

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/9/43
(Month) (Day) (Year)

(c) Place: burial or cremation Hillcrest, Mtn. Grove, Mo.

18. (a) Signature of funeral director Russell Barber

(b) Address Mtn. Grove, Mo.

19. (a) 11/9/43 (Date received local registrar) (b) Amblow (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 R. A. Ryan (M. D. or other) 11/9-43
Address Mtn. Grove, Mo. Date signed 11/9-43

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 6,

District File Number 1243-1397

Date Filed DEC 30 1943

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. 3848

working under my personal supervision.

Signed.....

Russell Barber
Licensed Embalmer No. 3848

P. O. Address Wtn. Grove, Md.

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 44141
Registrar's No. 51

Registration District No. 378

Primary Registration District No. 6285

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

1. PLACE OF DEATH:

(a) County Wright
(b) City or town Wright
(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 Lawrence Gardner 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 Dec 23
(Month) (Day) (Year)

8. AGE: Years 54 Months 12 Days _____ 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) _____ (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 no.
year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 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 R. A. Ryan (M. D. or other) _____

Address Wright Mo Date signed 3-2-44

SUPPLEMENTARY

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

S 44141