. S. No. 2
DM—8-43
v. 5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 9 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 23615

Registration District No. 47 Primary Registration District No. 4068 Registrar's No. 235

1. PLACE OF DEATH:
(a) County Callaway
(b) City or town Mokane (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 years, months or days) In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Callaway 14
(c) City or town Mokane (If outside city or town limits, write "RURAL") 0
(d) Street No. (If rural, give location) 0
(e) Citizen of foreign country? no. (Yes or No) 0
If yes, name country

3. (a) PRINT FULL NAME Dorcas Elizabeth Tate
3. (b) If veteran, name war —
3. (c) Social Security No. —
4. Sex F.
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Samuel Warren Tate
6. (c) Age of husband or wife if alive 80 years
7. Birth date of deceased Aug. (Month) 27 (Day) 1864 (Year)

8. AGE: Years	Months	Days	If less than one day
80	10	21	hr. min.

9. Birthplace Montgomery Co. (City, town, or county) Mo (State or foreign country)
10. Usual occupation House-wife
11. Industry or business
FATHER 12. Name Harrison Cole
13. Birthplace Virginia (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name Harriett Kellick
15. Birthplace Virginia (City, town, or county) (State or foreign country)
16. (a) Informant W. L. Tate
(b) Address Mokane, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof July 24, 1945 (Month) (Day) (Year)
(c) Place: burial or cremation Mokane, Mo.
18. (a) Signature of funeral director Glen G. Mangin
(b) Address 712 Court St. Fulton, Mo.
19. (a) 7-24-1945 (Date received local registrar) (b) Josie Mossinkoff (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 22 year 1945 hour 12 minute 20 A.M.
21. I hereby certify that I attended the deceased from May, 1935, to July 22, 1945, that I last saw her alive on July 11, 1945, and that death occurred on the date and hour stated above.

Immediate cause of death Diabetic Coma.
Due to Diabetes
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations
Of autopsy

Duration

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

23. Signature R. M. Stevens (M. D. or other)
Address Fulton Mo Date signed 7/23/45

1147 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9
District File Number
Date Filed 8-7-45

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 Glen G. Maupin

Licensed Embalmer No. 2725

P. O. Address Fulton 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.