S. No. 2
OM—5-43
v. 5-17-39
o I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED JAN 12 1946

State File No. 39853

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11084

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

1. PLACE OF DEATH:

(a) County

(b) City or town ST LOUIS
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: BARNES HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 HRS. (Specify whether
In this community 5 HRS.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State ILLIONIS (b) County MARION

(c) City or town CENTRALLIA
(If outside city or town limits, write "RURAL")

(d) Street No. — NR.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME JUSTIN DEAN TATE

3. (b) If veteran, name war YES. W. W. No 2

3. (c) Social Security No.

4. Sex MALE

5. Color or race WHITE

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

6. (b) Name of ~~husband~~ or wife VIRGINIA

6. (c) Age of ~~husband~~ or wife if alive 22 years

7. Birth date of deceased OCTOBER (Month) 28 (Day) 1922 (Year)

8. AGE:

Years	Months	Days	If less than one day
23	1	19	hr. min.

9. Birthplace CENTRALLIA (City, town, or county) ILL (State or foreign country)

10. Usual occupation SALESMAN

11. Industry or business

FATHER
12. Name WILLIAM TATE
13. Birthplace (City, town, or county) KY (State or foreign country)

MOTHER
14. Maiden name ELLA O'KEEFE
15. Birthplace SUNFIELD (City, town, or county) ILL (State or foreign country)

16. (a) Informant DONALD TATE
(b) Address CENTRALLIA, ILL

17. (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof 12-19-1945 (Month) (Day) (Year)
(c) Place: burial or cremation CENTRALLIA ILL

18. (a) Signature of funeral director BOGGS FUNERAL HOME
(b) Address CENTRALLIA ILL

19. (a) DEC 19 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month DECEMBER day 17
year 1945 hour 7 minute P M.

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

Immediate cause of death Hemorrhage and shock following gunshot wound of left Axilla when he tripped and fell while hunting of rubber touch of Valmalle Illinois
Due to
Due to Ground 5:00 P.M. Dec 16, 1945 Carrying the gun he was carrying to be discharged
Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations 184.08
Of autopsy 3.7

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) Accident
(b) Date of occurrence Dec 17 1945
(c) Where did injury occur? St Louis Mo (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Public Place (Specify type of place)
While at work? (e) Means of injury Co [illegible]

23. Signature Alfred J. Perry (M.D. or other)
Address Deputy Coroner Date signed 12/19/45

(Licensed Embalmer's Statement on Reverse Side)

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.....John Ketter.....

Licensed Embalmer No.....3880.....

P. O. Address.....St. Louis 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.