

WED JAN 25 1941

Registration District No. 689

Primary Registration District No. 3033

Registrar's No.

1. PLACE OF DEATH

(a) County Pike  
(b) City or town Louisiana  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution Pike County Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 days  
(Specify whether years, months or days) 1

3. (a) PRINT FULL NAME Mae Tate (no middle name)

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife John William Tate 6. (c) Age of husband or wife if alive 35 years

7. Birth date of deceased August 18 1908  
(Month) (Day) (Year)

8. AGE: Years 33 Months 4 Days 3 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation housewife

11. Industry or business \_\_\_\_\_

12. Name Felix Dillion

13. Birthplace Montgomery Co. Missouri  
(City, town, or county) (State or foreign country)

14. Maiden name Cora Bilcher

15. Birthplace Montgomery Co. Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Pike County Hospital

(b) Address Louisiana, Mo.

17. (a) \_\_\_\_\_ (b) Date thereof 12-22-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Clarksville Mo.

18. (a) Signature of funeral director Harvey Harroel

(b) Address Clarksville, Mo.

19. (a) 12-21-40 (b) B. H. Haley  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Pike  
(c) City or town Annada  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location) 0  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 21  
year 1940 hour 5 minute 20 P. A. M.

21. I hereby certify that I attended the deceased from December 18, 1940 to Dec. 21, 1940; that I last saw her alive on December 21, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Septicemia Duration \_\_\_\_\_

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) Months of injury \_\_\_\_\_

23. Signature B. H. Haley (M. D. \_\_\_\_\_) Address Louisiana, Mo. Date signed \_\_\_\_\_

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

12  
5  
1

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 10

District File Number: 6-41-60

Date Filed JAN 7 1941

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

*None*

Registered Apprentice No.

working under my personal supervision.

Signed

*None*

Licensed Embalmer No.

P. O. Address

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.