

FEB 17 1941

2909.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 3

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH:

(a) County Jackson
 (b) City or town Rural - Washington
 (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 _____
 In this community _____
 years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
 (c) City or town Rural, Washington
 (d) Street No. _____
 (e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME SARAH E. PATE

8. (b) If veteran, name war _____ (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 J. M. Pate
 6. (c) Age of husband or wife if alive 79 years
 7. Birth date of deceased July 13 1868
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>72</u>	<u>5</u>	<u>27</u>	hr. _____ min.

9. Birthplace Attica, Indiana
 (City, town, or county) (State or foreign country)

10. Usual occupation at home

11. Industry or business _____

MOTHER FATHER
 12. Name John Adams
 13. Birthplace Unknown
 14. Maiden name Rachel A. Waldrop
 15. Birthplace Unknown

16. (a) Informant J. M. Pate
 (b) Address Hickman Mills, Mo.

17. (a) Burial (b) Date thereof Jan 13, 1941
 (c) Place: burial or cremation Forest Hill, R.C., Mo.

18. (a) Signature of funeral director E. H. Geary & Sons
 (b) Address Grandview, Mo.

19. (a) 2-3-41 (b) Major J. Brennan
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day January
 year 1941 hour 9 minute 30 P. M.

21. I hereby certify that I attended the deceased from _____ 19 _____ 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 Carcinomatous uterus
ovaries

Due to Carcinoma of uterus, cervix & bladder

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? _____
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
366 (Specify type of place) _____
 While at work? _____ (e) Means of injury _____

23. Signature Shallace H. Graham (M. D. or other) M.D.
 Address 5-18 Argyle Bldg. Date signed 1-11-41

Duration 6 yrs.

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

Dr. Wallace H. Burham
518 Angelle Bldg.

48

LEGAL RECORD

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 A. R. George
Licensed Embalmer No. 3645
P. O. Address Grandview, 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 2909

Registration District No. 404

Primary Registration District No. 5558

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Washington T.P.
(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 Sarah E. Pate

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

4. Sex 7 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 _____ year

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years 72 Months 5 Days 27 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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 _____ (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) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 10
year 1945 hour _____ minute _____ 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 Carcinomatous Primary Carcinoma of Cervix uterina Duration 6 yrs.

Due to Carcinoma of uterus
Due to Cervix and bladder

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) (b) Means of injury _____

23. Signature Hellace H. Graham (M. D. or other) _____
Address 5-18 Argyle Bldg Date signed 4-10-45

SUPPLEMENTAL RECORD

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

PHYSICIAN

Underline the cause to which death should be charged statistically.

