

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-009611

STATE FILE NUMBER

Registration District No. 383 Primary Registration District No. 5655 Registrar's No. 2

AMENDED

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FILED MAR 23 1961

1. PLACE OF DEATH
a. COUNTY **LAWRENCE**

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE **Missouri** b. COUNTY **BARRY**

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN **Mt. VERNON** Length of stay in lb **3 yrs**

c. CITY OR TOWN **Seligman** Inside Limits Yes No

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION **MO. STATE SANATORIUM** Inside Limits Yes No d. STREET ADDRESS **R-1** (If outside, give location) Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First **EDWARD** Middle **C.** Last **TATE** 4. DATE OF DEATH Month **MARCH** Day **17** Year **1961**

5. SEX **MALE** 6. COLOR OR RACE **WHITE** 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH **9-2-1891** 9. AGE (last birthday) **68** IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **FARMER** 10b. KIND OF BUSINESS OR INDUSTRY **FARMING** 11. BIRTHPLACE (City and state or country) **Missouri** 12. CITIZEN OF WHAT COUNTRY **U.S.A.**

13a. FATHER'S NAME **GRAHAM R. TATE** 13b. MOTHER'S MAIDEN NAME **DORA BEAVER** 14. NAME OF HUSBAND OR WIFE **MRS. Ed. TATE**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes, give war or dates of service) **NO** 16. SOCIAL SECURITY NO. 17. INFORMANT Address **MO. STATE SAN. Mt. VERNON, MO.**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **CORONARY INSUFFICIENCY**
DUE TO (b) **GEN. ARTERIOSCLEROSIS**
DUE TO (c) **DIABETIS MELLITUS**
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) **PULMONARY Tuberculosis** PART III. If deceased was female was there a pregnancy in last 90 days. Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT SUICIDE HOMICIDE 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from **5-2-57** to **3-17-61** and last saw him alive on **3-17-61**
Death occurred at **1:25 PM** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) **H. Vernon Langelutsky M.D.** 22b. ADDRESS **MO. STATE SAN., Mt. VERNON, 377-4** 22c. DATE SIGNED

23a. BURIAL, CREMATION, REMOVAL (Specify) **Removal** 23b. DATE **3-18-61** 23c. NAME OF CEMETERY OR CREMATORY **GATEWAY Cemetery** 23d. LOCATION (City, town, or county) **GATEWAY ARK.** Mo. (State)

24. FUNERAL DIRECTOR ADDRESS **Miller-Sisco - Pear Ridge Ark.** 25. DATE RECD. BY LOCAL REG. **Mar 18 - 1961** 26. REGISTRAR'S SIGNATURE **H W Fassett**

MAY 4 1967

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 _____, Student Embalmer No. _____
working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Max L Fossett

Licensed Embalmer No.

4252

P. O. Address

Memphis, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.