MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

APR 24 1936

12196

V. S. No. 2.

PLACE OF DEATH.
County: St Francois — Registration District No. 774 — File No. 291
Township: St Francois — Primary Registration District No. 601813 — Registered No.
City: Esther — (No. .... St. .... Ward)

FULL NAME: Louisa Tucker

(a) Residence. No. .... St., ... Ward. (Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U.S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): married

If MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: G. H. Tucker

DATE OF BIRTH (MONTH, DAY AND YEAR): Oct 2nd 1854

AGE: Years 81 — Months 5 — Days 24 — If LESS than 1 day, ... hrs. or ... min.

OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (CITY OR TOWN): Madison Co
(STATE OR COUNTRY): Mo

10. NAME OF FATHER: Granville Umfleet
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY): Ill.
12. MAIDEN NAME OF MOTHER: Rachel Counts
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY): Mo.

INFORMANT: G. H. Tucker
(Address): Esther Mo.

FILED 4/4 1936 — C B Farrar, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Mar 26 1936

17. I HEREBY CERTIFY, That I attended deceased from Jan 1934, to Mar 26 1936, that I last saw her alive on Mar 25 1936, and that death occurred, on the date stated above, at .... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chr myocarditis
asthma
93C
(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (SECONDARY): Arterio sclerosis
(duration) ... yrs. ... mos. ... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? no — DATE OF
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Exam

(Signed) C A Appleberry, M. D
, 19 — (Address) Flat River Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Woodlawn Cemetery
DATE OF BURIAL: 3-27 1936

20. UNDERTAKER: Caldwell Bros
ADDRESS: Flat River

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Atherosma

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

U. S. No. 2.

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No.....

City..... (No..... ..... St. ..... W

2. FULL NAME .....

(a) Residence. No..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

5a. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or .....min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY)

14.
INFORMANT .....
(Address)

15.
FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

17.
I HEREBY CERTIFY, That I attended deceased from .....
....., 19....., to ....., I
that I last saw h..... alive on....., 19....., a
death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

.....(duration).....yrs. .....mos.....

CONTRIBUTORY.....
(SECONDARY)

.....(duration)..... ..yrs. .....mos.....

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed).....

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIA

20. UNDERTAKER	ADDRESS