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.

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

11963

PLACE OF DEATH

County: Christian

Township or Village or City: Sparta

Registration District No.: 185

File No.:

Primary Registration District No.: 5258

Registered No.: 11

(NO. ..... St.: ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME: Abner Rucker

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: white

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Married

DATE OF BIRTH: Feb (Month) 28 (Day), 1858 (Year)

AGE: 56 yrs. 1 mos. 26 ds.

If LESS than 1 day, ... hrs. or ..... min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): Farm work

BIRTHPLACE (City or town, State or foreign country): Christian Co Mo

PARENTS

NAME OF FATHER: Clayborn Rucker

BIRTHPLACE OF FATHER (City or town, State or foreign country): Tenn.

MAIDEN NAME OF MOTHER: Elizabeth Dalton

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Tenn

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): Mary M. Rucker

(ADDRESS): Sparta Mo.

Filed Apr 25 1914 R. R. Farthing REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Apr (Month) 24 (Day), 1914 (Year)

I HEREBY CERTIFY, that I attended deceased from Mar 25, 1914, to Mar 27, 1914, that I last saw him alive on Mar 27, 1914, and that death occurred, on the date stated above, at 5:30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

131

(Duration) 5 yrs. ..... mos. ..... ds.

150

Contributory (SECONDARY)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R. R. Farthing M. D.

Apr 25 1914 (Address) Sparta Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL: Shipman Cem.

DATE OF BURIAL: Apr 26 1914

UNDERTAKER: J. C. Barnes

ADDRESS: Sparta Mo

Revised United States Standard Certificate of Death

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

PLACE OF DEATH

County.....

Township ..... Registration District No..... File No.....

or

Village..... Primary Registration District No..... Registered No.....

or

City .....(NO....., ...St.:.....Ward)

[If death occ hospital or i give its NAM of street and n

FULL NAME.....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

....., 1.....
(Month) (Day) (Year)

AGE

.....yrs.....mos.....ds.

If LESS than 1 day, ...hrs. or .....min.?

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

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

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant).....

(ADDRESS).....

Filed ....., 191...., ...
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

.....
(Month) (Day)

I HEREBY CERTIFY, that I attended deceas

....., 191...., to.....

that I last saw h.....alive on.....

and that death occurred, on the date stated above, at.....

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(Duration).....yrs.....mos.....

Contributory.....
(SECONDARY)

.....(Duration).....yrs.....mos.....

(Signed).....

....., 191..... (Address).....

*State the Disease Causing Death, or, in deaths from Violent Ca (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANS RECENT RESIDENTS)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....

Where was disease contracted if not at place of death? .....

Former or usual residence.....

PLACE OF BURIAL OR REMOVAL	DATE OF BURI
UNDERTAKER	ADDRESS