

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

Do not use this space.

**1. PLACE OF DEATH**

County.....  
Township..... *St Louis*  
City..... (No. ....) St. .... Ward)

Registration District No. *791*  
Primary Registration District No. *1003*

File No. *28654*  
Registered No. *8101*

**2. FULL NAME**

*Margaret (Kacher) Tucker*  
(a) Residence, No. *4521 Kennerly Ave* Ward. *11*  
(Usual place of abode)

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

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX *Female* 4. COLOR OR RACE *W* 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) *March 26/1916*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<i>13</i>	<i>4</i>	<i>10</i>		

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work *School girl*  
(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) *MO*

10. NAME OF FATHER *Edgar Anderson Tucker*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *St Louis County*

12. MAIDEN NAME OF MOTHER *Margaret Tucker*

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

14. INFORMANT *Mary M. Tucker*  
(Address) *4521 Kennerly Ave*

15. FILED *ALG* REGISTRAR *Ray E. Stashley*

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *8-5-1928*

17. I HEREBY CERTIFY, That I attended deceased from *3/20/28*, 19... to *8-5-28*, 19... that I last saw h. & c. alive on *8-5-28*, 19... and that death occurred, on the date stated above, at *7:30 P. M.*

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

*Edeo carditis chronic*  
*Myocarditis chr.*  
*Cardiac hypertrophy*  
*5 yrs.* (duration) *2 or more years* de.

CONTRIBUTORY (SECONDARY) *Athropsy*  
(duration) *1* yrs. mos. da.

18. WHERE THIS 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? *Dr. Ray*  
(Signed) *Ray E. Stashley* M. D.

(Address) *718 Beaumont Med Bldg*

\*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.

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

*Greenwood* *8/9 1928*

20. UNDERTAKER ADDRESS *Ray E. Stashley*

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.

RECORD

PARENTS

4

