

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

Do not use this space.

40808

**1. PLACE OF DEATH**

County Jackson Registration District No. 399  
 Township Kaw Primary Registration District No. 1002  
 City W.C. Mo. (No. Mercy Hospital) St. \_\_\_\_\_ Ward \_\_\_\_\_  
 Registered No. 5184

**2. FULL NAME**

(a) Residence. No. Blatche, Kans. 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

**3 MEDICAL CERTIFICATE OF DEATH**

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

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-15 1978

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

17. I HEREBY CERTIFY, That I attended deceased from 11-25, 1978, to 12-15, 1978  
 that I last saw h. u alive on 12-15-78, 1978, and that death occurred, on the date stated above, at 2:00 a. m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 11-18-27  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.  
1 0 27

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Abscess left thigh  
15213  
21-14  
 (duration) yrs. 1 mos. 7 da.

8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work Widow  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
 (c) Name of employer \_\_\_\_\_

CONTRIBUTORY (SECONDARY) Septicemia  
 (duration) yrs. \_\_\_\_\_ mos. 6 da.

9. BIRTHPLACE (CITY OR TOWN) Blatche, Kans  
 (STATE OR COUNTRY)

18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH: Blatche, Kans

10. NAME OF FATHER Hard Tucker

2 DID AN OPERATION PRECEDE DEATH: yes DATE OF 11-27-78  
 WAS THERE AN AUTOPSY: yes

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

WHAT TEST CONFIRMED DIAGNOSIS: Findings  
 (Signed) Dr. J.H. Montgomery, M.D.  
12-16-78 (Address) Route Bdg

12. MAIDEN NAME OF MOTHER Ann Lee  
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY) Ky

\*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.

14. INFORMANT Jessie Ward Tucker  
 (Address) Blatche, Mo.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Blatche Kansas DATE OF BURIAL Dec, 1978  
 20. UNDERTAKER Mrs. C.L. Foster ADDRESS K.C. Mo.

15. FILED 17/18 25 M.M. Cronin REGISTRAR

PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is very important.



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

ALL INFORMATION REQUESTED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH.**

County.....

Registration District No. 399

File No. ....

Township.....

Primary Registration District No. 1002

Registered No. 6-184

City.....

(No. ....)

St. ....

Ward.....

**2. FULL NAME**

(a) Residence, No. ....  
(Usual place of abode)

St. ....

Ward. ....

(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**

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

S

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)

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

12/15/28 M. M. Crooney  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-15-28

17.

I HEREBY CERTIFY, That I attended deceased from

19.....

to

19.....

that I last saw him alive on

19.....

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

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Access left thigh  
non tubercular  
(Pyogenic)

CONTRIBUTORY (SECONDARY)

Septicemia

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).....

M. D

, 19 (Address)

\*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

Dec 15 19 28

20. UNDERTAKER

ADDRESS

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-4088

1928