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

Do not use this space.

31374

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

City St. Louis (No. City Hospital St. ..... Ward)

File No. .....

Registered No. 8978

2. FULL NAME Catherine Tucker

(a) Residence. No. 4617 Shenandoah 17 Ward.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

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 14-1930

7. AGE: YEARS | MONTHS: 6. | 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) Mo.
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Emmett Tucker

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

12. MAIDEN NAME OF MOTHER Marie Manigr

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

14. INFORMANT Roman
(Address) City Hospital

15. FILED SEP 15 1930 Max C. Starkey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2-

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 14 1930

17. I HEREBY CERTIFY, That I attended deceased from Aug 14, 1930 to Sept 14, 1930 that I last saw h. N alive on Sept 14, 1930, and that death occurred, on the date stated above, at 5:30 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Furuncle
151 B
36 (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Purulent infection.
Septicemia (Not Puerperal) (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? Clinical & Laboratory

(Signed) Raymond G. Jacobs, M.D.
9/15/30 (Address) City Hospital

*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: Calvary Cemetery | DATE OF BURIAL: Sept 16 1930

20. UNDERTAKER: H. Gebken L. & U. Co. 2842 Meramec | ADDRESS

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

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