

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

Do not use this space.

32959

1. PLACE OF DEATH

County Jackson Registration District No. 399
 Township Kaw Primary Registration District No. 1002
 City Kansas City (No. 814 Locust) St. _____ Ward _____

File No. _____
 Registered No. 4138
 St. _____ Ward _____

2. FULL NAME

Ray Tucker
 (a) Residence No. 814 E. 14th St. 7 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 <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR WIFE OF) <u>Fern Tucker</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Sept 22, 1900</u>		
7. AGE	YEARS	MONTHS
	<u>30</u>	<u>0</u>
		22
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Window Cleaner</u> (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer <u>K. C. Window Cleaning Co.</u>		

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

PARENTS	10. NAME OF FATHER <u>Henry Clay Tucker</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) <u>Halleenville</u> (STATE OR COUNTRY) <u>Missouri</u>
	12. MAIDEN NAME OF MOTHER <u>Ora</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) <u>Knoxville</u> (STATE OR COUNTRY) <u>Ohio</u>

14. INFORMANT Mrs. Fern Tucker
 (Address) 814 E. 14th St.

15. FILED 10/15 1930 M. M. Cronus
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, and that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
accidental Fract
skull
1863
1949 (duration) yrs. mos. ds.

CONTRIBUTORY Fall from building
 (SECONDARY) while working (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? Skull X-rays
 (Signed) Harvey M. Crow M. D.
10/14 1930 (Address) Hopkins Corner

*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 <u>Centralia, Mo.</u>	DATE OF BURIAL <u>Oct 15 1930</u>
20. UNDERTAKER <u>D. W. Newcomer's Sons</u>	ADDRESS <u>2116 E. 9th St.</u>

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.

Mr. Stanley M. Hall
531 Argyle Bldg.