

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.

FEB 24 1932

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

Do not use this space.  
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1. PLACE OF DEATH  
 County Greene Registration District No. 318  
 Township Springfield Primary Registration District No. 2051  
 City Springfield No. 633 College St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME Sarah Alice Kuckabey  
 (a) Residence, No. 633 College St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (Usual place of abode) Springfield Mo (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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 6-12-1908

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>26</u>	<u>9</u>	<u>8</u>	

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housework

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. 244

10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo 1

13. NAME Thomas Kuckabey

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

15. MAIDEN NAME Dora Kuckabey

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown 31

17. INFORMANT Thomas Kuckabey  
 (ADDRESS) 633 College St Springfield

18. BURIAL, CREMATION, OR REMOVAL  
 PLACE East Lawn DATE 1-21-1932

19. UNDERTAKER W. F. Thomas  
 (ADDRESS) Springfield Mo

20. FILED 1-21-1932 For Sharp  
 Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-20-1932

22. I HEREBY CERTIFY, That I attended deceased from Jan 11, 1932, to 1-20-1932  
 I last saw him alive on ( ) 9, 1932. Death is said to have occurred on the date stated above, at 6:00 AM  
 The principal cause of death and related causes of importance were as follows:  
IIA: Influenza pneumonia 1-11-32  
10:28  
 Other contributory causes of importance IIA  
Influenza 1-10-32

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? clinical Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place. \_\_\_\_\_

Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_ D

24. Was disease or injury in any way related to occupation of deceased? No  
 If so, specify \_\_\_\_\_  
 (Signed) Arthur J. Knapp M. D.  
 (Address) Springfield Mo.

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