

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

Do not use this space.

27475

1. PLACE OF DEATH *St. Francois's*
 County *St. Francois* Registration District No. *1115*
 Township *Liberty* Primary Registration District No. *6021*
 City *Marion* (No. *R. Tuggle*) St. _____ Ward _____

2. FULL NAME *James Tuggle*
 (a) Residence, No. _____ 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. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *widowed*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Wife dead several years*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Jan. 20, 1857*

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
<i>76</i>	<i>6</i>	<i>15</i>	

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

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

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) *Illinois*

13. NAME *James Tuggle*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Unknown*

15. MAIDEN NAME *Unknown*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Unknown*

17. INFORMANT *C. P. Tuggle*
 (ADDRESS) *Marion, Mo.*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Knob Lick Cem.* DATE *Aug. 6, 1933*

19. UNDERTAKER *Rolla Coe*
 (ADDRESS) *Harmulation, Mo.*

20. FILED *8/5* 19 *33* *F. J. A. Rydeen*
 Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Aug. 5*, 19 *33*

22. I HEREBY CERTIFY, That I attended deceased from *Feb. 2nd*, 19 *32* to *Aug 4*, 19 *33*
 I last saw him/her alive on *Aug 4*, 19 *33* Death is said to have occurred on the date stated above, at *12:30* p.m.
 The principal cause of death and related causes of importance were as follows:
Apoplexy
followed by convulsions
Paralysis

Other contributory causes of importance:
87 A
87 D

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ 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 _____

24. Was disease or injury in any way related to occupation of deceased? *no*
 If so, specify _____
 (Signed) *M. B. Barber*, M. D.
 (Address) *Fredericktown Mo*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S SIGNATURE AND CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

SEP 26 1933

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