

REC'D MAR 15 1939

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

Do not use this space.

1. PLACE OF DEATH

County CaldwellRegistration District No. 95Township 1Primary Registration District No. 5141

City

(No. _____)

St. _____

Ward _____

2. FULL NAME

Mrs. O. W. Tucker. Eva Else Tucker

(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

Female

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

O. W. Tucker

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

Dec. 27, 1857

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION

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

Housewife

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

MOTHER FATHER

13. NAME

Henry Elser

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

England

15. MAIDEN NAME

Caroline Payne

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

New York

17. INFORMANT (ADDRESS)

Frank Simpsonson

18. BURIAL, CREMATION, OR REMOVAL

PLACE

Council No

DATE

2-17-39

19. UNDERTAKER (ADDRESS)

Chas. A. Reed Council No.

20. FILED

2/201939Mr. M. W. Forbes

Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb. 16, 1939, 1922. I HEREBY CERTIFY That I attended deceased from Feb. 14, 1939, 19, to Feb. 16, 1939, 19I last saw Her alive on Feb. 16, 1939, 19. Death is saidto have occurred on the date stated above, at 3 P. m.

The principal cause of death and related causes of importance were as follows:

Hemiplegia. followed by Hypostatic Pneumonia.

Date of onset

Other contributory causes of importance:
Artero SclerosisName of operation no

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 _____

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify _____

(Signed) Henry H. Patterson

M. D.

(Address) Braymer, Mo.

99

W.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.

828

INDEXED
District of Columbia
Serial File Number 39-120
Date Filed 1957-10-15

RECORDED
INDEXED
OCT 15 1957
FBI - WASH DC

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

6053
Do not use this space.

1. PLACE OF DEATH
 (a) County Caldwell Registration District No. 95
 (b) Township Lincoln Primary Registration District No. 5140
 (c) City..... (d) Street No..... St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.
 2. PRINT FULL NAME Eva. Elsie Tucker
 (a) Residence, No. St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED wid
 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. ormin.
81 0 19
 OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as 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)
 FATHER
 13. NAME
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)
 MOTHER
 15. MAIDEN NAME
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)
 17. INFORMANT (ADDRESS)
 18. BURIAL, CREMATION, OR REMOVAL PLACE DATE
 19. FUNERAL DIRECTOR (ADDRESS)
 20. FILED 4/18/1939 Mrs M D Forbes Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-16-1939
 22. I HEREBY CERTIFY, That I attended deceased from 19..... to 19.....
 I last saw h..... alive on 19..... Death is said to have occurred on the date stated above, at..... m.
 The principal cause of death and related causes of importance were as follows:
Hemiplegia followed by Hypostatic Pneumonia following cerebral hemorrhage Date of onset
 Other contributory causes of importance:
Arterio Sclerosis
 Name of operation..... Date of.....
 What test confirmed diagnosis?..... Was there an autopsy?.....
 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?
 If so, specify Henry H. Patterson, M. D.
 (Signed) Blagman, Mrs
 (Address)

A CONTINUING SMALL FEE FOR CERTIFICATED UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

SUPPLEMENT

