

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.

JAN 19 1940

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

1531

Do not use this space.

1. PLACE OF DEATH

(a) County Andrew Registration District No. 921  
 (b) Township Ferber Primary Registration District No. 557  
 (c) or City Ferber (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. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

August T. Tuckner  
 (a) Residence, No. Ferber Mo St.  (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>7</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Widow</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>August Tuckner</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Jan 18-1876</u>		
7. AGE YEARS <u>63</u>	MONTHS <u>11</u>	DAYS <u>28</u>
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>House Wife</u>		
9. Industry or business in which work was done, as saw mill, bank, etc. <u>Own home</u>		
10. Date deceased last worked at this occupation (year) <u>Jan 9-1940</u>		
11. Total time (years) spent in this occupation		
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Mo</u>		
13. NAME <u>Henry Pfeffering</u>		
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Germany</u>		
15. MAIDEN NAME <u>Minie Reese</u>		
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Ger</u>		
17. INFORMANT (ADDRESS) <u>Lucie Pfeffering</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Ferber Mo</u> DATE <u>Jan 12 1940</u>		
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>W. B. Mace</u>		
20. FILED <u>Jan 17th, 1940</u>		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan. 10th. 1940

22. I HEREBY CERTIFY, That I attended deceased from Jan. 10th. 12.30a. M. to Jan. 10th, 1940

I last saw her alive on Jan 10th, 1940. Death is said to have occurred on the date stated above, at 1-A. m.

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

Angina-Pectoris (Acute) Date of onset  
1-9-40

Other contributory causes of importance: 94

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 \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? No.  
 If so, specify \_\_\_\_\_

(Signed) W. B. Mace, M. D.  
94 (Address) Ladonia Mo.

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed Wm B. Coates

Licensed Embalmer No. 3321-

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**