

FILED MAR 14 1940

Registration District No. 378

Primary Registration District No. 4222

State File No. \_\_\_\_\_

Registrar's No. 12

1. PLACE OF DEATH:

(a) County Howard  
(b) City or town Fayette, Mo.  
(c) Name of hospital or institution: # 2  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME Mary Thomas Rucker, 2100

8. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife E. W. Rucker 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased March 23 1857  
(Month) (Day) (Year)

8. AGE: Years 82 Months 10 Days 19 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Missouri, O  
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Edward Rucker  
13. Birthplace Missouri O  
14. Maiden name Harriett Thomas O  
15. Birthplace Missouri O  
(City, town, or county) (State or foreign country)

16. (a) Informant Harriett Rucker  
(b) Address Fayette, Mo.

17. (a) Burial (b) Date thereof 2/ 18th 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Walnut Ridge, Cem

18. (a) Signature of funeral director Guy T. Halley  
(b) Address Fayette, Mo. 230

19. (a) Mar. 6 - 1940 V. C. Bonham  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Howard  
(c) City or town Fayette  
(If outside city or town limit- write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 16th  
year 1940 hour \_\_\_\_\_ minute 3 P. M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_ to Feb 16, 1940  
that I last saw h. er alive on Feb 16, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Occlusion Duration 2-12-40

Due to Coronary occlusion

Due to Mild hypertension

Other conditions age 94 1/2  
(Include pregnancy within 3 months of death)

Major findings: Of operations none

Of autopsy none

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

(Specify type of place) \_\_\_\_\_  
While at work \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature Mr. J. Shaw (M. D. or other) 1  
Address Fayette, Mo. Date signed 3-4-40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED  
District Health Officer No. 8  
District File Number  
Date Filed 3-18-40

**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

*Ralph A. Carr*

Licensed Embalmer No.

*3340*

P. O. Address

*Jayette Mo.*

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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 6785-

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 378

Primary Registration District No. 4222

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Howard  
(b) City or town Fayette  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community \_\_\_\_\_ (Specify whether  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Howard  
(c) City or town Fayette  
(If outside city or town limits write "RURAL")  
(d) Street No. Lynn Street  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

3. (a) PRINT NAME Mary Thomas Rucker

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex 7 5. Color or race w 6. (a) Single, widowed, married divorced wid

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

7. Birth date of deceased. (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
82 10 19 hr. min.

9. Birthplace. (City, town, or county) (State or foreign country)

10. Usual occupation.

11. Industry or business.

12. Name.

13. Birthplace. (City, town, or county) (State or foreign country)

14. Maiden name.

15. Birthplace. (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address.

17. (a) (b) Date thereof. (Month) (Day) (Year)

(c) Place: burial or cremation.

18. (a) Signature of funeral director.

(b) Address.

19. (a) Feb. 5-1940 (b) V. C. Barkner  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH. Month Feb day 16  
year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19 \_\_\_\_\_ to \_\_\_\_\_ 19 \_\_\_\_\_

that I last saw him alive on \_\_\_\_\_ 19 \_\_\_\_\_ and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions. (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

(Specify type of place) While at work? (e) Means of injury \_\_\_\_\_

23. Signature M. J. Shaw (M. D. or other)

Address Fayette Mo signed \_\_\_\_\_

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTAL COPY

S-6785