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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

14021

State File No.

Registrar's No.

1733

Registration District No. 399

Primary Registration District No. 1002

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

1. PLACE OF DEATH:

(a) County JACKSON
(b) City or town KANSAS CITY, MO
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 135 N. TOPPING
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 22 YEARS
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County JACKSON
(c) City or town 135 N. TOPPING
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME JAMES AUSTIN TUCKER ²⁶²

3. (b) If veteran, name war NONE 1916-03-50 ^(b) Social Security No. NONE

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife RINDA TUCKER 6. (c) Age of husband or wife if alive 55 years

7. Birth date of deceased APRIL 13 1885
(Month) (Day) (Year)

8. AGE: Years 55 Months 0 Days 8 If less than one day _____ hr. _____ min.

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

10. Usual occupation W.P.A. WORKER

11. Industry or business _____

MOTHER FATHER { 12. Name JOHN TUCKER

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

14. Maiden name ADDIE DEIDS

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

16. (a) Informant MRS. RINDA TUCKER

(b) Address 135 N. TOPPING K.C. MO.

17. (a) BURIAL (b) Date thereof APRIL 24 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MAPLE HILL CEM

18. (a) Signature of funeral director JOHN P. SHEIL

(b) Address 6606 INDEP. AVE. K.C. MO.

19. (a) April 23, 1940 (b) M. M. Brown
(Date entered local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ day 4-21-40
year _____ minute _____

21. I hereby certify that I attended _____ deceased from _____ 19____ to _____ 19____;
that _____ was alive on _____ 19____ and that death occurred on the date and hour stated above.
Immediate cause of death _____ Duration _____

10:20-30 turns of face & entire body

Due to _____ 180
Due to _____ 15

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

Major findings: Of operations _____ Of autopsy _____

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

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

(b) Date of occurrence 4-21-40

(c) Where did injury occur K.C. MO
(City or town) (County) (State)

(d) Did injury occur in or about home or farm, in industrial place, in public place?
Summed while home was a fire
(Specify type of place) _____

While at work? _____

23. Signature Walter P. Schubert Date signed 5
Address K.C. MO

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.....

Joe B. Yoder
working under my personal supervision.

AV, Registered Apprentice No. #233

Signed J. B. Yoder

Licensed Embalmer No. 3625

P. O. Address B. C. 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. _____

Y 151900

Registration District No. _____

Primary Registration District No. _____

Registrar's No. 1733

1. PLACE OF DEATH:

- (a) County _____
- (b) City or town _____
(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 _____
years, months or days

8. (a) PRINT FULL NAME James Austin Tucker

8. (b) If veteran, name war _____ 8. (c) Social Security No. 496-03-5027

4. Sex _____ 5. Color or race _____ 8. (a) Single, widowed, married, divorced _____

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
				hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER {

12. Name _____

18. 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 4/23/40 (b) Sm. M. Browne
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State _____ (b) County _____
- (c) City or town _____
(If outside city or town limits, 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 Apr day 21 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 _____

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? _____

While at work? _____
(Specify type of place) (c) Means of injury

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

5-14021

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.....

Licensed Embalmer No.....

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.