

Registration District No. 653

Primary Registration District No. 5871

Registrar's No. 65

1. PLACE OF DEATH:

(a) County Pemiscot  
 (b) City or town Cragsford Rural  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution None  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 2  
 (Specify whether years, months or days) years

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County Pemiscot  
 (c) City or town Deering  
 (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 R. C. Tucker 60

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) 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 Pearl Tucker 6. (c) Age of husband or wife if alive 56 years

7. Birth date of deceased: (Month) 2 (Day) 28 (Year) 1882

| 8. AGE: | Years     | Months   | Days      | If less than one day |
|---------|-----------|----------|-----------|----------------------|
|         | <u>58</u> | <u>4</u> | <u>16</u> | hr. _____ min. _____ |

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

10. Usual occupation laborer

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

MOTHER FATHER { 12. Name Fugh Tucker 9

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

14. Maiden name \_\_\_\_\_

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

16. (a) Informant Woodrow Tucker

(b) Address Deering mo

17. (a) Burial (b) Date thereof: (Month) 7 (Day) 15 (Year) 40

(c) Place: burial or cremation maple cem.

18. (a) Signature of funeral director J. S. Smith

(b) Address Caruthersville mo

19. (a) 7/12/40 (b) Pearl Kelly (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 14 year 40 hour 2 minute \_\_\_\_\_ P.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 Heart Carbolic Acid, about 2 g.

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

Other conditions (include pregnancy within 3 months of death) 16

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

Duration \_\_\_\_\_  
 PHYSICIAN \_\_\_\_\_  
 Underlines 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) suicide

(b) Date of occurrence 7/14/40

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

(d) Did injury occur in or about home, on farm, in industrial place, in public place? 5

946. (Specify type of place) home While at work? no (e) Means of injury poison

23. Signature Jack Kelly (M. D. or other) owner

Address Deering mo Date signed 7/14/40

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

8-40-7

---

---

**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 noel c Sheen

Licensed Embalmer No. 3941

P. O. Address Caruthersville, 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

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. 25915-  
Registrar's No. 65-

Registration District No. 653

Primary Registration District No. 5871

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

1. PLACE OF DEATH:

(a) County Pemiscot  
(b) City or town Braggadocio T.P.  
(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.....  
In this community..... (Specify whether years, months or days)

3. (a) PRINT FULL NAME R. C. Tucker

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

4. Sex m 5. Color or race W 6. (a) Single, widowed, married, divorced m

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 58 Months 4 Days 16 If less than one day..... 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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) 7/15/40 (b) Pearl Kelley  
(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 7 day 14  
year..... hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....; that last saw h..... 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) (e) Means of injury.....

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

Address..... Date signed.....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTAL COPY

