34866

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 0

FILED SEP 21 1946

Registration District No. 8 27

Primary Registration District No. 6076

Registrar's No. 3012

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Manchester (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Manchester Nursing Home + Sanatorium (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 year 2 months (Specify whether years, months or days)

In this community 1 year 2 months

2. USUAL RESIDENCE OF DECEASED:

(a) State California (b) County Lassen 999

(c) City or town Herlong 4 (If outside city or town limits, write "RURAL")

(d) Street No. 916 Sierra Drive 0 (If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 2

If yes, name country

3. (a) PRINT FULL NAME Ruby Tucker (Ettelee)

3. (b) If veteran, name war —

3. (c) Social Security No. —

4. Sex female

5. Color or race white

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Willie P. Tucker

6. (c) Age of husband or wife if alive 44 years

7. Birth date of deceased August 4, 1909 (Month) (Day) (Year)

8. AGE: Years 37 | Months 2 | Days 6 | If less than one day ___ hr. ___ min.

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

10. Usual occupation House wife

11. Industry or business Own home

FATHER
12. Name Augustus Slayer
13. Birthplace Fredericktown, Mo. (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Kelly
15. Birthplace Dulin, Mo. (City, town, or county) (State or foreign country)

16. (a) Informant Willie P. Tucker

(b) Address Herlong, California

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation New Madrid, Mo.

18. (a) Signature of funeral director Schrader Funeral Home

(b) Address Ballwin, Mo.

19. (a) 10-14-46 (Date received local registrar) (b) Ruth L. Allen MD (Registrar's signature) MSL

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Oct. day 11 year 1946 hour 5 30 minute A M.

21. I hereby certify that I attended the deceased from Feb 3, 1946, to Oct 11, 1946 that I last saw her alive on Oct. 10, 1946 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Epilepsy following brain injury	3 hrs
Due to Fracture Skull with 5 operations	
Due to	
Other conditions Diabetic (Include pregnancy within 3 months of death)	

Major findings: Of operations 61

Of autopsy N.M.I.

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 0

23. Signature C H Denning MD (M. D. or other) MD

Address Creve Coeur, Mo Date signed 10-11-46

(Licensed Embalmer's Statement on Reverse Side)

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 Harry F. Schrader

Licensed Embalmer No. 2091

P. O. Address Ballwin Mo.

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

If this body is not embalmed, fact should be so stated above.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 1101

Registration District No. 317 Primary Registration District No. 6076 Registrar's No. 3012

1. PLACE OF DEATH:

(a) County: St Louis

(b) City or town: Manchester
(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 years, months or days)
In this community

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) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: Ruby E. Tucker

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex: F

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: Aug 4 1940 (Month) (Day) (Year)

8. AGE: Years 37 Months 2 Days 6 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

MOTHER
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) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug Day 11 year 1946 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: Injury to head previous to brain operations

Due to: apparently occurred in California State, Date not definite. Our records do not include it

Due to:

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

Major findings of operation: Suggest Barnes Hospital contacted if further information is necessary

Of autopsy: Cbt Dr mny

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. D. or other)
Address Date signed

SUPPLEMENTARY

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