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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 11 1948
389

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 3712

Registration District No. 389

Primary Registration District No. 6179

Registrar's No.

1. PLACE OF DEATH:

(a) County Sullivan
(b) City or town Milan Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Jackson Twp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 88 (Specify whether years, months or days)

3. (a) PRINT FULL NAME Sarah Adaline Tucker

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

4. Sex fem / 5. Color or race w
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife John T Tucker
6. (c) Age of husband or wife if alive Acad years
7. Birth date of deceased 3 - 13 - 1859 (Month) (Day) (Year)

8. AGE: Years 88 Months 10 Days 2 If less than one day hr. min.

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

10. Usual occupation Farmer wife

11. Industry or business

12. Name Lewis H. B. Deeds
13. Birthplace ~~West~~ Indiana (City, town, or county) (State or foreign country)
14. Maiden name Sarah A Newman
15. Birthplace ~~Don't know~~ Ia (City, town, or county) (State or foreign country)

16. (a) Informant Lawrence Tucker (b) Address Milan Mo

17. (a) Burial (b) Date thereof 1/17/48 (Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Deeds Cem.

18. (a) Signature of funeral director Schaefer (b) Address Milan Mo

19. (a) Feb 2 - 1948 (b) Mrs. H. B. Harris (Date received on local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Sullivan
(c) City or town Milan Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Jackson Twp.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 15 year 1948 hour 10 minute 30 a.m.

21. I hereby certify that I attended the deceased from Sept 1947 to Jan 15 1948 that I last saw her alive on Jan 5 1948 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis

Due to _____

Due to _____

Other conditions: Hypertension (Include pregnancy within 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 J. R. McArthur (M. D. or other) Address Branning Mo Date signed _____

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

105
0
0

105
0
0

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECORDED
INDEXED
DATE FEB - 9 1948
CROSS No. 70
2-48-248

STATEMENT BY LICENSED EMBALMER

Date Filed

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 Dwight Richards

Licensed Embalmer No. 2667

P. O. Address Milan, 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, fact should be so stated above.