

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

2462

1. PLACE OF DEATH

County..... *St. Francis* Registration District No..... *775*
Township..... *Perry* Primary Registration District No..... *6040*
City..... *Camden* (No.....) St..... Ward.....

File No.....
Registered No. *3*

2. FULL NAME

Mary James Tucker

(a) Residence No..... St..... Ward.....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *F* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *married*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

Henry Tucker

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Oct 4 - 1853*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
76 3

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... *House wife*
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN) *St. Francis Mo.*
(STATE OR COUNTRY)

10. NAME OF FATHER *William Barron*

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY) *St. Francis Mo.*

12. MAIDEN NAME OF MOTHER *Carshan Milledent*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY) *Mo.*

14. INFORMANT *Mrs. Lizzie Williams*
(Address) *M. L. Lammert, Mo.*

15. FILED *1/4 1930* *T. A. Son* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Jan 4 - 1930*

17. I HEREBY CERTIFY, That I attended deceased from *Sept 1929* to *Jan 4 - 1930* and that I last saw her alive on *Dec 28*, 1929, and that death occurred, on the date stated above, at *630 a.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cancer of intestine
4 to 6 (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) *urkissum*
(duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED *+*
IF NOT AT PLACE OF DEATH.....

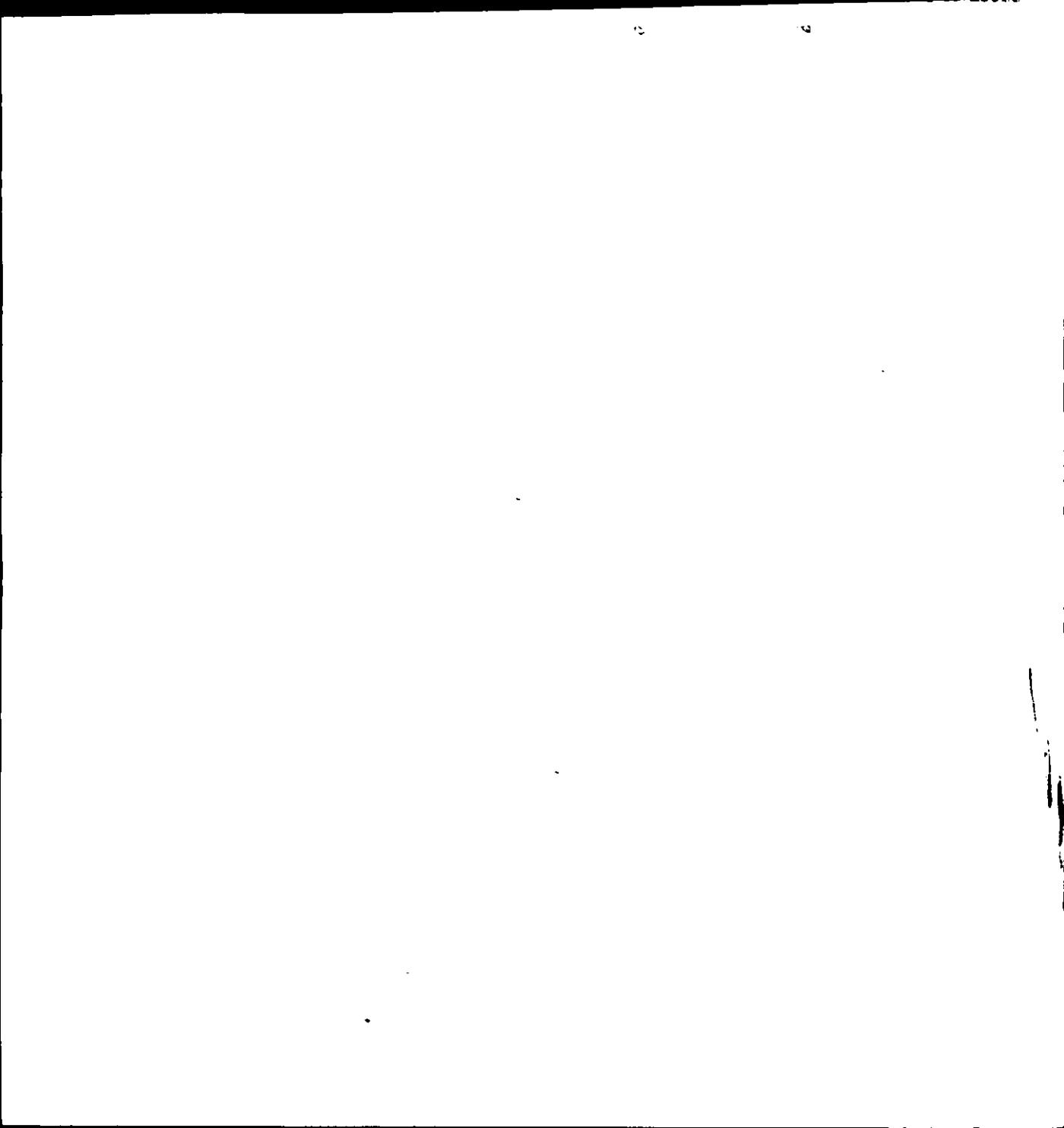
DID AN OPERATION PRECEDE DEATH..... *no* DATE OF *+*

19. WHAT TEST CONFIRMED DIAGNOSIS..... *Physical et*
(Signed)..... *A. J. Tucker, M. D.*

(Address) *Camden Mo.*
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *Gordon Cemetery* DATE OF BURIAL *Jan 5 1930*

20. UNDERTAKER *Raymond Calhoun* ADDRESS *Flat Kin*



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ALL INFORMATION REQUESTED
HEREIN MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

1. PLACE OF DEATH
 County St. Francois Registration District No. 975 File No. _____
 Township Deary Primary Registration District No. 6020 Registered No. 3
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME Mary Jane Tucker
 (a) Residence No. _____ St. _____ Ward _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>F</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>M</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR)		
7. AGE	YEARS	MONTHS
8. OCCUPATION OF DECEASED		
(a) Trade, profession, or particular kind of work		
(b) General nature of industry, business, or establishment in which employed (or employer)		
(c) Name of employer		
9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)		
10. NAME OF FATHER		
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)		
12. MAIDEN NAME OF MOTHER		
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)		

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 4 1930

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cancer of intestine
Primary seat - Gall-bladder
 (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH _____
 DID AN OPERATION PRECEDE DEATH _____ DATE OF _____
 WAS THERE AN AUTOPSY? _____
 WHAT TEST CONFIRMED DIAGNOSIS _____
 (Signed) _____, M. D.
 _____, 19____ (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

14. INFORMANT _____ (Address) _____

15. FILED 4/16 1930 T. T. Son REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

5-2462