

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

Do not use this space.

**31519**

**1. PLACE OF DEATH**

County.....

Registration District No. 701

Township.....

Primary Registration District No. 1003

City St. Louis No. City Hosp #2

File No. ....

Registered No. 9132

St. .... Ward)

**2. FULL NAME**

(a) Residence. No. 2037 Angus St. 22 Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. .... mos. .... ds. How long in U.S., if of foreign birth? .... yrs. .... mos. .... ds.

**PERSONAL AND STATISTICAL PARTICULARS**

**3. SEX**

Male

**4. COLOR OR RACE**

Col

**5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)**

single

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

**6. DATE OF BIRTH (MONTH, DAY AND YEAR)**

1-16-1901

**7. AGE**

YEARS	MONTHS	DAYS	If LESS than 1 day, .... hrs. or .... min.
<u>24</u>	<u>7</u>	<u>29</u>	

**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

Laborer  
Odd jobs

**9. BIRTHPLACE (CITY OR TOWN)**

(STATE OR COUNTRY)

La

**10. NAME OF FATHER**

Rufus Tucker

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY)

La

**12. MAIDEN NAME OF MOTHER**

Unknown

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY)

Unknown

**14. INFORMANT (Address)**

A. Gertrude Creath  
City Hosp #2

**15. FILED**

22 1930

M. C. Starke  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)**

9-15 1930

17. I HEREBY CERTIFY That I attended deceased from 87 31 1930 to 9/15 1930 that I last saw him alive on 9/15 1930, and that death occurred, on the date stated above, at 12 25 m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Tuberculosis  
Ch. 12. Meningitis of the  
Meninges (duration) .... yrs. .... mos. 7 ds. **23A**

**CONTRIBUTORY (SECONDARY)**

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH, .....

Home

DID AN OPERATION PRECEDE DEATH? .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) A. A. Weather M. D.  
9/16 1930 (Address) City Hospital #2

\*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**

Mother's Dickson

**DATE OF BURIAL**

Sept 29 1930

**20. UNDERTAKER**

J. E. Pope

**ADDRESS**

29314 Lucas

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state EXACTLY. AGE should be carefully supplied.

