



MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **27464**

Registration District No. **399**

Primary Registration District No. **1002**

Registrar's No. **3097**

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

1. PLACE OF DEATH:

(a) County **Jackson**
(b) City or town **Kansas City, Mo.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
2618 E. 28th St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community **2 years**
years, months (of days) **Malissa Frances Rucker**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**
(c) City or town **Kansas City**
(If outside city or town limits, write "RURAL")
(d) Street No. **2618 E. 28th St.**
(If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

3. (a) PRINT FULL NAME **MALISSA FRANCES RUCKER**

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

4. Sex **Female** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife **J. J. Rucker** 6. (c) Age of husband or wife if alive **— years**
Birth date of deceased **July 15 1857**
(Month) (Day) (Year)

8. AGE: Years **83** Months **0** Days **16** If less than one day hr. _____ min.

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

10. Usual occupation **at home**

11. Industry or business _____

12. Name **Peter Stubbs**

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

14. Maiden name **Luminda Kerr**

15. Birthplace **Ky.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. W. N. Hamilton**

(b) Address **2618 East 28th, K. C. Mo.**

17. (a) **Burial** (b) Date thereof **Aug 3, 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Palastine Cem., Hickman, Mo.**

18. (a) Signature of funeral director **E. H. Young, Sr.**

(b) Address **Springfield, Mo.**

19. (a) **Aug. 2, 1940** (b) **M. M. Brown**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug.** day **1**
year **1940** hour **80** minute **2** A. M.

21. I hereby certify that I attended the deceased from **7-12-40**
~~8-1-40~~ 19 to **8-1-40** 19
that I last saw her alive on **8-1-40** 19
and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary thrombosis**
basal

Duration **19 da**

Due to **95%**

Due to _____

Other conditions **Arteriosclerosis**
(Include pregnancy within 3 months of death)
heart disease

Major findings: Of operations _____

Of autopsy _____

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? _____

While at work? _____ (Specify type of place) (e) Means of injury **!**

23. Signature **Robert M. Myers** (M. D. or other)

Address **1025 Quaker Bldg** Date signed **8-2-40**

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

A. K. George

Licensed Embalmer No. *3675-*

P. O. Address *Grandview St*

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.