

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

10157

Do not use this space.

FILED APR 14 1943

1. PLACE OF DEATH
 (a) County Dunklin Registration District No. 107
 (b) Township _____ Primary Registration District No. 3019
 (c) City Summit Mo (d) Street No. 1 Registered No. 29
 (e) Length of residence in city or town where death occurred 30 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME LUC CRISHA THACKER
 (a) Residence, No. 309 East St St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widow

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec 25 - 1866

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
76 2 11

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Thacker wife
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year) 1942
 11. Total time (years) spent in this occupation.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Landon Canby Tenn

FATHER 13. NAME David Ford

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Uniontown

MOTHER 15. MAIDEN NAME Carline Ford

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Uniontown

17. INFORMANT (ADDRESS) Mr J B Ford 309 East St Summit Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE oak Ridge DATE 3-7-43

19. FUNERAL DIRECTOR (NAME) (ADDRESS) W J Turner & Son Hannibal Mo

20. FILED 3-7- H J Blank Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 5 - 1943

22. I HEREBY CERTIFY, That I attended deceased from 2/28 1942 to 3-6 1943
 I last saw him alive on 3/5/43 1943. Death is said

to have occurred on the date stated above, at 5A m.
 The principal cause of death and related causes of importance were as follows:

Uremic Poisoning

Other contributory causes of importance: Iron Deficiency

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no
 If so, specify _____
 (Signed) D J Dempsey, M. D.
 (Address) Summit Mo

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

3-7-43

RECEIVED

District Health Office No. 2,

District File Number 443-441

Date Filed 4-2-43

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

Licensed Embalmer No.

P. O. Address

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 10157
Registrar's No. 29

Registration District No. 107

Primary Registration District No. 2019

1. PLACE OF DEATH:

(a) County Dunklin
(b) City or town _____
(c) Name of hospital or institution: Kenneth
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME Lucrisa Thacker

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 W

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased: Dec 23
(Month) (Day) (Year)

8. AGE: Years 76 Months 2 Days _____
(If less than one day _____ min.)

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

10. Usual occupation _____

11. Industry of business _____

MOTHER FATHER { 12. Name _____
13. Birthplace _____
(City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MAR
year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____;
that I last saw him _____ 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic meningitis

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 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)
(e) Means of injury _____

23. Signature D. J. Dempsey, M.D. (M. D. or other)

Address Remitt. Mo. Date signed _____

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

SUPPLEMENTARY

13212

PHYSICIAN

Underline the cause to which death should be charged statistically.

By Ritty W Paul

