

Registration District No. 1000

Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County _____
 (b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Homer G. Phillips/Hosp.
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 5 mos. 6 days
(Specify whether
 In this community Unknown
years, months or days)

3. (a) PRINT
FULL NAMERosie Tucker 7/08. (b) If veteran,
name war _____8. (c) Social Security
No. _____4. Sex Female5. Color or
race Col.6. (a) Single, widowed, married,
divorced Widowed

6. (b) Name of husband or wife

Unknown

6. (c) Age of husband or wife if

alive _____ years

7. Birth date of deceased

Oct.
(Month)5
(Day)1869
(Year)

8. AGE:

Years

70

Months

0

Days

19

If less than one day

hr. _____ min.

9. Birthplace

Tipton(City, town, or county)Mo.(State or foreign country)

10. Usual occupation

house work

11. Industry or business

12. Name Unknow13. Birthplace Unknow(City, town, or county)(State or foreign country)14. Maiden name unknow15. Birthplace unknow(City, town, or county)(State or foreign country)

16. (a) Informant's own signature

(b) Address 1020 N. Leffingwell ave.17. (a) Burial(b) Date thereof Oct. 30/39(Burial, cremation, or removal)(Month) (Day) (Year)(c) Place: burial or cremation Washington Park.

18. (a) Signature of funeral director

Dement & Son.(b) Address 2629-31 Wash St.19. (a) Oct 29 1939(Date received local registrar)J. F. Puder
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
 (c) City or town St. Louis 21
(If outside city or town limits, write "RURAL")
 (d) Street No. 1029 N. Leffingwell
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 24
 year 1939 hour 12:10 minute _____ P. _____ M.

21. I hereby certify that I attended the deceased from
6-18- 1939 to 10-24- 1939
 that I last saw her alive on 10-24- 1939
 and that death occurred on the date and hour stated above.

Immediate cause of death

Arteriosclerotic Dementia 2-3-yrs.

Duration

Due to Bronchopneumonia 7 days

Due to _____

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations _____

Of autopsy _____

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

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)

Means of injury _____

23. Signature Leann Smart (M. D. or other)
 Address 2601 N. Whittier Date signed 10-25-1939

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 Arthur L. Hilliard

Licensed Embalmer No. 3389

P. O. Address. 3028 Dickson

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.