

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

41535

State File No. _____

Registration District No. 701

Primary Registration District No. _____

Registrar's No. 10658

1. PLACE OF DEATH: 1008

(a) County _____

(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: City Hospital, #1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 13 Days
(Specify whether _____)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 805 Market St.
(If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME William Tucker 260

3. (b) If veteran, name war _____

3. (c) Social Security No. None

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____

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

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

8. AGE: Years About 53 Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace: St. Louis Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation: Newspaper Vender

11. Industry or business _____

MOTHER FATHER { 12. Name Frank Tucker 9

13. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

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

16. (a) Informant's own signature Charles Sims

(b) Address 4140 Louisiana Ave.

17. (a) Burial (b) Date thereof 12-14-39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bethany

18. (a) Signature of funeral director Wm. Schumacher

(b) Address 3013 Meramec St.

19. (a) DEC 13 1939 (b) J. F. Brudeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 11,
year 1939 hour 2:55 minute P. M.

21. I hereby certify that I attended the deceased from November
29, 1939 to December 11, 1939
that I last saw h im alive on December 11, 1939
and that death occurred on the date and hour stated above.

Immediate cause of death Urinary extravasation

Due to Urinary strictures

Due to _____

Other conditions Pulmonary Tuberculosis
(Include pregnancy within 3 months of death)

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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 Kenneth L. Carter (M. D. or D. O.)

Address 1515 Lafayette, 12/12/39
Date signed

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.....

Clarence J. Rochow

....., Registered Apprentice No.....

working under my personal supervision.

Signed

Clarence J. Rochow

Licensed Embalmer No. **3093**

P. O. Address **3013 Meramec 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.