

S. No. 2
1-2-40
5-17-39
I X231

APR 15 1941 85

Primary Registration District No. 1001

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

1. PLACE OF DEATH:

(a) County BUCHANAN

(b) City or town ST. JOSEPH
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: STATE HOSPITAL No. 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 yrs. 10 mo. 9 da.
(Specify whether years, months or days)

In this community 4 yrs. 10 mo. 9 da.

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Clay

(c) City or town Excelsior Spgs. 24
(If outside city or town limits, write "RURAL")

(d) Street No. 1 (If rural, give location)

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

3. (a) PRINT FULL NAME John Wm. Tucker

(b) If veteran, name war _____ (c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar. day 25 year 1941 hour 12-30 minute P. M.

4. Sex male 5. Color or race white

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

6. (b) Name of husband or wife Bessie Tucker 6. (c) Age of husband or wife if alive 3 years

7. Birth date of deceased Jan. 27 1898
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from May 16, 1936, to Mar. 25, 1941, that I last saw him alive on 11, 1941, and that death occurred on the date and hour stated above.

8. AGE: Years 63 Months 1 Days 28 If less than one day hr. min.

Immediate cause of death broncho pneumonia 2 wks.

Due to Arteriosclerosis

Due to _____

9. Birthplace Mo. 11
(City, town, or county) (State or foreign country)

Other conditions had rickets
(Include pregnancy within 3 months of death)

Major findings: hemipleg.

MOTHER FATHER

10. Usual occupation Coal miner

11. Industry or business _____

12. Name John Tucker

13. Birthplace Mo. 0
(City, town, or county) (State or foreign country)

14. Maiden name Cynthia Tucker

15. Birthplace Mo. 11
(City, town, or county) (State or foreign country)

Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant Pern Tucker, 614 Park Ave.

(b) Address Excelsior Spgs.

17. (a) Removal (b) Date thereof 3 25 41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Crown Cem. Garden Mo

18. (a) Signature of funeral director Gibson & Son

(b) Address Orville, Mo.

19. (a) 3/26/41 (b) H. M. McElhiney
(Date received by local registrar) (Registrar's signature)

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? 85

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature T. J. O'Neil (M. D. or other) J. M. D.

Address St. Joseph Date signed 3/25/41

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JUL 8 1942

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 *J. C. Gibson*

Licensed Embalmer No. *4137*

P. O. Address *Quick, Missouri*

...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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 10136

Registrar's No. 338

Registration District No. 85-

Primary Registration District No. 1001

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(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)

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 _____

3. (a) PRINT FULL NAME

John Wm Tucker

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

4. Sex m 5. Color or race W 6. (a) Single, widowed, married, divorced Div

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

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

8. AGE: Years 63 Months 1 Days 28 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or 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 (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 25th
year 1941 hour _____ minute _____ M.

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

Immediate cause of death Bronchopneumonia Duration _____

arterio Sclerosis
Due to _____

Due to ggt

Other conditions Bed ridden
(Include pregnancy within 3 months of death)

Major findings: Wemiplegia
Of operations sequela to cerebral hem.
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 J. J. O'Dell (M. D. or other) _____
Address _____ Date signed _____

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

SUPPLEMENTARY

S-10136 1941

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, fact should be so stated above.