No. 2
—1/47
5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED OCT 4 1947

Registration District No. 318

MISSOURI DIVISION OF HEALTH
# STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 33094
Registrar's No. 8951

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 Hospital 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 11 days (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 000
(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No. 622 a So Garrison 9
(If rural, give location)
(e) Citizen of foreign country? 18 (Yes or No) 0
If yes, name country

3. (a) PRINT FULL NAME Harold Tucker
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex Male 2
5. Color or race Col
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Brelie Tucker
6. (c) Age of husband or wife if alive years
7. Birth date of deceased May (Month) 7 (Day) 1892 (Year)

8. AGE: Years 55 | Months 4 | Days 14 | If less than one day hr. min.

9. Birthplace Miss. (City, town, or county) (State or foreign country) 1
10. Usual occupation Laborer
11. Industry or business

FATHER
12. Name Columbus Tucker 9
13. Birthplace Unknown (City, town, or county) (State or foreign country) 1

MOTHER
14. Maiden name Sussanna ?
15. Birthplace Unknown (City, town, or county) (State or foreign country) 9

16. (a) Informant Brelie Tucker, wife 1
(b) Address 622 a So Garrison
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof SEP 24 47 (Month) (Day) (Year)
(c) Place: burial or cremation Father Dickson
18. (a) Signature of funeral director F. A. GREEN
(b) Address 4726 Delmar Blvd
19. (a) SEP 25 1947 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 21 year 1947 hour 1 minute 35 A M.

21. I hereby certify that I attended the deceased from Sept. 10 1947 to Sept. 21 1947 that I last saw him alive on Sept. 21 1947 and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death: Subarachnoid Hemorrhage | Undet. |
| Due to | |
| Due to | |
| Other conditions: None (Include pregnancy within 3 months of death) | |

Major findings:
Of operations
Of autopsy: No

PHYSICIAN — Underline the cause of 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? (Specify type of place)
While at work? (e) Means of injury 0

23. Signature Oscar L. Daniels (M. D. or other)
Address 2601 N Whittier Date signed 9/24/47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

## 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. G. Green

Licensed Embalmer No. 9963

P. O. Address 4214 Dalman

**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.