FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED AUG 9 1948

Registration District No. ____

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 22294

Primary Registration District No. 1000

Registrar's No. 825

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: 1 mo 10 days (Specify whether years, months or days)
In this community: 1 mo 10 days

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo (b) County: Atchison 3
(c) City or town: Rockport 1
(If outside city or town limits, write "RURAL")
(d) Street No.: Rockport 0
(If rural, give location) 1
(e) Citizen of foreign country: yes (Yes or No)
If yes, name country: England

3. (a) PRINT FULL NAME: William Tuck
3. (b) If veteran, name war: ✓
3. (c) Social Security No.: ✓

4. Sex: male 0
5. Color or race: white
6. (a) Single, widowed, married, divorced: married 1
6. (b) Name of husband or wife: Mary Mrs William Tuck
6. (c) Age of husband or wife if alive: not given
7. Birth date of deceased: Dec (Month) 12 (Day) 1874 (Year)

8. AGE: Years 73 Months 7 Days 14 If less than one day ____ hr. ____ min.

9. Birthplace: unknown (City, town, or county) England (State or foreign country) 4
10. Usual occupation: Farmer
11. Industry or business:
FATHER
12. Name: John Tuck
13. Birthplace: not given (City, town, or county) not given (State or foreign country) 9
MOTHER
14. Maiden name: Mary Thompson
15. Birthplace: not given (City, town, or county) not given (State or foreign country) 9
16. (a) Informant: Mrs Mary Tuck
(b) Address: Rockport Mo
17. (a) Burial: (Burial, cremation, or removal) (b) Date thereof: 7-27-48 (Month) (Day) (Year)
(c) Place: burial or cremation: Rockport Mo
18. (a) Signature of funeral director: Barry Funeral Home
(b) Address: St Joseph Mo
19. (a) Date received local registrar: Aug 5, 1948 (b) E C Jenkins (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: July day: 26 year: 1948 hour: 3 minute: 30 P.M.
21. I hereby certify that I attended the deceased from July 1, 1948 to July 26, 1948; that I last saw him alive on July 26, 1948; and that death occurred on the date and hour stated above.

Duration

Immediate cause of death: Chronic Myocarditis
Due to: Arteriosclerosis
Due to:
Other conditions (Include pregnancy within 3 months of death):
Major findings:
Of operations:
Of autopsy:

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:

23. Signature: Forest Jones (M. D. or other)
Address: St Joseph Mo Date signed: 7/26-48
(Licensed Embalmer's Statement on Reverse Side) of State Hospital No 2

Jefferson City Printing Co.

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

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.....Victor Barry.....

Licensed Embalmer No.....4212.....

P. O. Address.....St Joseph mo.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.