

Registration District No. _____

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:
(a) County St. Louis, Missouri
(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:
Homer G. Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 30 yrs years, months or days)

3: (a) PRINT FULL NAME Rosie Tucker
3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Female 5. Color or race Negro
6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife dead 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased September 15, 1871
(Month) (Day) (Year)

8. AGE: Years 76 Months 10 Days 22 If less than one day _____ hr. _____ min.

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

10. Usual occupation Nil

11. Industry or business _____

MOTHER FATHER 12. Name John Worthy

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

14. Maiden name Julia ? (City, town, or county) (State or foreign country)

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

16. (a) Informant Agnes Jackson

(b) Address 2702 Delmar Blvd.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/12/48 (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood Cemetery

18. (a) Signature of funeral director C.W. Roberts

(b) Address 1416 N. Taylor Ave.

19. (a) AUG 10 1948 (Date received local registrar) (b) J.F. Bruback (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Louis
(c) City or town St. Louis (If outside city or town limits, write "RURAL")
(d) Street No. 2704 A. Delmar Blvd. (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Aug day 6th year 1948 hour 11 minutes 20 P. M.
21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____,
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis
Diabetes I, Chronic
Due to Interstitial Nephritis
Due to _____
Other conditions (Include pregnancy within 3 months of death) 61

Major findings: Of operations _____
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) (c) Means of injury 3
23. Signature Patricia E. Taylor (M. D. or other) _____
Address _____ Date signed 8/12/48

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 Annie Roberts

Licensed Embalmer No. 4439

P. O. Address 1416 N. Taylor

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.