

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **18635**
 Registrar's No. **4243**

FILED MAY 19 1952

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BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Illinois b. COUNTY Richland	
b. CITY OR TOWN ST. LOUIS, MO.		c. CITY OR TOWN Olney 8120	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) 217 So. Lincoln St. 8	
d. FULL NAME OF HOSPITAL OR INSTITUTION BARNES HOSPITAL			

3. NAME OF DECEASED (Type or Print) a. (First) ROBERT b. (Middle) LEE c. (Last) TUCKER			4. DATE OF DEATH (Month) (Day) (Year) 5 6 52		
5. SEX Male 0	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH June 22, 1918	9. AGE (in years last birthday) 33	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper		10b. KIND OF BUSINESS OR INDUSTRY Garage		11. BIRTHPLACE (City and State or Foreign Country) Olney, Ill.	
12. CITIZEN OF WHAT COUNTRY? U.S.					

13a. FATHER'S NAME Voile Tucker		13b. MOTHER'S MAIDEN NAME Bessie Woods		14. NAME OF HUSBAND OR WIFE Margaret	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 497-01-6250		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Margaret Tucker, Olney, Ill.	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)			MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH 24 HRS.		
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) SUBARACHNOID HEMORRHAGE			DUE TO (b) INTERCRANIAL ANEURYSM					
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.			DUE TO (c) POLYCYSTIC KIDNEY					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.								

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 452X			

22. I hereby certify that I attended the deceased from **MAY 5, 1952**, to **MAY 6, 1952**, that I last saw the deceased alive on **May 6, 1952**, and that death occurred at **3:55A m.**, from the causes and on the date stated above.

23a. SIGNATURE FR Bradley 0 (Degree or title) M.D.		23b. ADDRESS BARNES HOSPITAL		23c. DATE SIGNED	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 5-6-52		24c. NAME OF CEMETERY OR CREMATORY Haven Hill	
24d. LOCATION (City, town, or county) (State) Olney, Ill.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe, 4700 Washington Blvd			
DATE REC'D BY LOCAL REG. MAY 6 1952		REGISTRAR'S SIGNATURE J. Carl Smith M.D.			

(Licensed Embalmer's Statement on Reverse Side)

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 Me

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Edmund H. Penelico

Licensed Embalmer No. 4283

P. O. Address St. Louis, Mo.

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.