

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED FEB 11 1953

State File No.

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 1034

1. PLACE OF DEATH
a. COUNTY _____
2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY _____

b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis c. LENGTH OF STAY (in this place) _____
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2229

d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital d. STREET ADDRESS (If rural, give location) 22 2735 a Hickory

3. NAME OF DECEASED a. (First) Anna b. (Middle) Mae c. (Last) Tucker 4. DATE OF DEATH (Month) (Day) (Year) Jan. 23 1953

5. SEX Female 6. COLOR OR RACE Negro 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 8. DATE OF BIRTH Feb. 7, 1917 9. AGE (In years last birthday) 35 IF UNDER 1 YEAR Months 11 Days 16 IF UNDER 24 HRS. Hours _____ Min. _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None 10b. KIND OF BUSINESS OR INDUSTRY _____ 11. BIRTHPLACE (City and State or Foreign Country) Greenville, Mississippi 12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Eddie Lee Marshall 13b. MOTHER'S MAIDEN NAME Christine Thomas 14. NAME OF HUSBAND OR WIFE Nelson Tucker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No 16. SOCIAL SECURITY NO. ? 17. INFORMANT'S SIGNATURE OR NAME Nelson Tucker ADDRESS 2735 A. Hickory

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.
MEDICAL CERTIFICATION
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bilateral Carcinoma of Breast with soft tissue metastasis INTERVAL BETWEEN ONSET AND DEATH Undet.
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____
DUE TO (c) _____
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION _____ 19b. MAJOR FINDINGS OF OPERATION _____ 20. AUTOPSY? YES NO

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) _____ 21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR? 170X

22. I hereby certify that I attended the deceased from 12-16, 19 52 to 1-23, 19 53, that I last saw the deceased alive on 1-23, 19 53, and that death occurred at 2 p m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Carl Rollins M. D. 23b. ADDRESS 2601 N. Whittier St 23c. DATE SIGNED 1-27-53

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 24b. DATE Jan. 29 1953 24c. NAME OF CEMETERY OR CREMATORY Wash. Park Cemetery 24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.

DATE REC'D BY LOCAL REG. JAN 29 1953 REGISTRAR'S SIGNATURE J. Earl Smith, M.D. 25. FUNERAL DIRECTOR'S SIGNATURE E.B. Koonce ADDRESS 1221 N. Grand

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Gupton Swan
Licensed Embalmer No. 4580

P. O. Address 1221st Grand E

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.