

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **753**BIRTH NO. _____ REG. DIST. NO. **86** PRIMARY REG. DIST. NO. **5329** Registrar's No. **4-1957**

1. PLACE OF DEATH a. COUNTY Crawford		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Crawford	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Cuba near Oakhill Twp 2 1/2 yrs		c. CITY OR TOWN Cuba	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION AT Home		e. STREET ADDRESS (If rural, give location) 12 mi. N.E. of Cuba on HWY C	

3. NAME OF DECEASED (Type or Print) a. (First) William b. (Middle) - Absolon c. (Last) - TUCKER			4. DATE OF DEATH (Month) (Day) (Year) 2-6-1957		
5. SEX male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH SEPT 2 1882		9. AGE (In years last birthday) 74
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Blacksmith		10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (City and State or Foreign Country) Decatur Co. TENN		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME FRANK TUCKER		13b. MOTHER'S MAIDEN NAME EILEEN ATKISSON		14. NAME OF HUSBAND OR WIFE MINNIE TAYLOR-Deed	
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. 490-24-6075A		17. INFORMANT'S SIGNATURE OR NAME MRS FOYE STEENBURGER - RT 2	
				ADDRESS Cuba MO.	

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.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH 5 yrs.	
		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.			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? 2 YES <input type="checkbox"/> NO <input checked="" 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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **March 15, 1957** to **Feb. 6, 1957**, that I last saw the deceased alive on **Feb 6, 1957**, and that death occurred at **2:45 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Donald H. Scott D.O.		23b. ADDRESS Sullivan Mo		23c. DATE SIGNED 2/6/57	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 2-8-57		24c. NAME OF CEMETERY OR CREMATORY Kinder Cemetery	
				24d. LOCATION (City, town, or county) (State) Cuba Mo.	
DATE REC'D BY LOCAL REG. 2-7-1957		REGISTRAR'S SIGNATURE P. D. G. [Signature]		25. FUNERAL DIRECTOR'S SIGNATURE Herman C. [Signature]	
				ADDRESS Cuba, Mo.	

FEB 28 1957

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.....
Signature of Student Embalmer

Signed.....
Hermon A. Hoover

Licensed Embalmer No. 4673

P. O. Address Cuba, N.Y.

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.