

R DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-028172

FILED VS SEP 8 1959 38

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 419

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Boone</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Boone</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia, Missouri</u>		Length of stay in 1b <u>1 1/2 Days</u>	c. CITY OR TOWN <u>Columbia</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>University Medical Center</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>106 Worley Street</u>		
3. NAME OF DECEASED (Type or print) First <u>HATTIE</u> Middle <u>Hubbard</u> Last <u>Tucker</u>			4. DATE OF DEATH Month <u>Sept.</u> Day <u>2</u> Year <u>1959</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>Negroid</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>6-8-1908</u>	9. AGE (last birthday) <u>51</u> IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Callaway Co. Mo.</u>		
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>			13a. FATHER'S NAME <u>PETER HUBBARD</u>			
13b. MOTHER'S MAIDEN NAME <u>Lucille (unknown)</u>			14. NAME OF HUSBAND OR WIFE <u>Ray Tucker</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>496-32-3709</u>	17. INFORMANT <u>Hospital Record Medical Center</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atelctasis</u>					INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Intracerebral hemorrhage & rupture into ventricular system. Probably Rt. side.</u>						
DUE TO (c) <u>Hypertension of unknown etiology</u>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <u>8-31-59</u> to <u>9-2-59</u> and last saw her/him alive on <u>11 PM 9-1-59</u> Death occurred at <u>7:20 AM 9-2-59</u> on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) <u>John Keith Logan MD</u>			22b. ADDRESS <u>University of Mo. Med Center</u>		22c. DATE SIGNED <u>9-2-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Sept 5 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Reckland</u>		23d. LOCATION (City, town, or county) (State) <u>Callaway Co Mo</u>		
24. FUNERAL DIRECTOR <u>Exeeman-Forindexter Columbia Mo</u>			25. DATE RECD. BY LOCAL REG. <u>Sept 4 1959</u>	26. REGISTRAR'S SIGNATURE <u>Mrs R E Palmer</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SEP 9 1959

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No. 0

working under my personal supervision.

Student [Signature]

Signature of Student Embalmer

Signed [Signature]

Licensed Embalmer No. 4220

P. O. Address [Signature]

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do 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.