

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-041306

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5679 STATE FILE NUMBER

FILED DEC 1 1961

DATE AWARDED

INSTEAD OF

DOCUMENT

SHOULD READ

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri , b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City	Length of stay in 1b 60 Yrs	c. CITY OR TOWN Kansas City	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Senior Estates Nursing Home 2323 Swope Parkway		d. STREET ADDRESS (If outside, give location) 1309 W. 100th Terrace	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Leta Middle Tucker Last Tucker	4. DATE OF DEATH Month November Day 10 Year 1961
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5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 5-3-82	9. AGE (last birthday) 79	IF UNDER 1 YEAR Months 8 Days 10 Hours 4 Min. 1	IF UNDER 24 HR Hours 4 Min. 1
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Lathrop, Missouri	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME Peter Hamilton Clark	13b. MOTHER'S MAIDEN NAME Mahalia Haynes	14. NAME OF HUSBAND OR WIFE Robert William Tucker
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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. None	17. INFORMANT Address Dr. Jay J. Carduff 5228 Linden
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) adrenal insufficiency, chronic		INTERVAL BETWEEN ONSET AND DEATH 8 years	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) arteriosclerotic heart disease		10 yrs
	DUE TO (c)		

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
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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.)
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20c. TIME OF INJURY Hour 11:12 a.m. P. 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 Kansas City	COUNTY Missouri	STATE
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21. I attended the deceased from 1955 to Nov 10, 1961 and last saw ^{her} him alive on Nov 10, 1961 Death occurred at 11:12 P. m on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) Jay J. Carduff, M.D.	22b. ADDRESS 6300 Glenwood, Shawnee, Missouri, Kan.	22c. DATE SIGNED 11-11-61
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 11-13-61	23c. NAME OF CEMETERY OR CREMATORY Mt. Moriah	23d. LOCATION (City, town, or county) (State) Kansas City, Missouri
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24. FUNERAL DIRECTOR ADDRESS Stine & McClure Kansas City, Missouri	25. DATE RECD. BY LOCAL REG. 11-13-61	26. REGISTRAR'S SIGNATURE Ruth Long
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DEPT. OF HEALTH

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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 Behav W Meeker

Licensed Embalmer No. 5078

P. O. Address RC, Md

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.