

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1967-2-17-59 I 119811

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 17479
Registrar's No. 2006

Registration District No. 399

Primary Registration District No. 1002

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
K. C. General Hospital No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 weeks
In this community 28 years (Specify whether years, months or days)

8. (a) PRINT FULL NAME ALBERT TUCKER
8. (b) If veteran, name war None
8. (c) Social Security No. None

4. Sex Male 5. Color or race W
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Laura E. Tucker
6. (c) Age of husband or wife if alive 67 years
7. Birth date of deceased October 1, 1868
(Month) (Day) (Year)

8. AGE: Years 71 Months 7 Days 12 If less than one day hr. min.

9. Birthplace Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation Retired

11. Industry or business
MOTHER FATHER {
12. Name George Tucker 9
13. Birthplace No Record 0
(City, town, or county) (State or foreign country)
14. Maiden name None 1
15. Birthplace No Record
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Laura Tucker
(b) Address 6711 Roberts K.C. Mo.

17. (a) Burial (b) Date thereof May 15 - 1940
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Washington

18. (a) Signature of funeral director Heid T. Underhill
(b) Address 6606 Indef. Ave. K.C. Mo.
19. (a) May 14, 1940 (b) M. M. Crome
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 6711 Roberts
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month May day 13th
year 1940 hour 5 minute 45 A. M.

21. I hereby certify that I attended the deceased from 4-6-40
_____, 19____, to 5-13-40, 19____;
that I last saw him alive on 5-13-40, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Bilateral bronchopneumonia
Duration _____

Due to Chronic gangrenous cystitis and ascending pyelonephritis

Due to 1320

Other conditions (include pregnancy within 3 months of death)

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy See above
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury 1

23. Signature P. J. DeMama M.D. (M. D. or other) _____
Supt. K. C. Gen. Hos p., K. C. MO.
Address _____ Date signed _____

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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, above space should be left blank.