DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 29727

Registration District No. 791 Primary Registration District No. 1003 Registrar's No. 7065

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

1. PLACE OF DEATH:

(a) County

(b) City or town St Louis Mo. (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: BARNES HOSPITAL (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 8-18-41 & 8-30-41 (Specify whether

In this community years, months or days)

2. USUAL RESIDENCE OF DEACESED:

(a) State Missouri (b) County 96

(c) City or town Jefferson City N.R. (If outside city or town limits, write "RURAL")

(d) Street No. 618 School Street (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME JOHN J. Harold Tucker Ker

3. (b) If veteran, name war World War

3. (c) Social Security No. 500-10-8486

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Jeanne Rose Tucker

6. (c) Age of husband or wife if alive 38 years

7. Birth date of deceased Oct. (Month) 17 (Day) 1897 (Year)

8. AGE: Years 43 Months 10 Days 18 If less than one day hr. min.

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

10. Usual occupation Auditor

11. Industry or business

MOTHER FATHER

12. Name Charles Tucker

13. Birthplace New York (City, town, or county) (State or foreign country)

14. Maiden name Margaret Doyle

15. Birthplace Davenport (City, town, or county) Iowa (State or foreign country)

16. (a) Informant Jeanne Rose Tucker

(b) Address Jefferson City, Mo.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 9/2/41 (Month) (Day) (Year)

(c) Place: burial or cremation Jefferson City, Mo.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Ave.

19. (a) SEP 2 1941 (Date received local registrar) (b) J. T. Broderick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 30 year 1941 hour 10 minute 30 P.M.

21. I hereby certify that I attended the deceased from 8-18-41 19 to 8-30 19 41 that I last saw him alive on 8-30 19 41 and that death occurred on the date and hour stated above.

Immediate cause of death Peritonitis

Due to following operation for lumbar sympathectomy, rt

Due to performed for occlusive vascular disease

Due to

Other conditions (Include pregnancy within 3 months of death) Amputation (old) of left leg

Major findings: Gangrene of foot - rt

Of operations

Of autopsy As above

Duration

PHYSICIAN

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature J. R. Bradley (M.D. or Coroner)

Address BARNES HOSPITAL Date signed 8-31-41

(Licensed Embalmer's Statement on Reverse Side)

SEP 1 8 1941

OCT 1 5 1941

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.....G W Wilkinson

Licensed Embalmer No.....3575

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to compl the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

. 2B
25-41
X27852

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

DEPARTMENT OF COMMERCE
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STANDARD CERTIFICATE OF DEATH

State File No.

FILED OCT 18 1941

Registration District No. Primary Registration District No. Registrar's No. 7065

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Barnes Hosp.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County

(c) City or town St. Louis (If outside city or town limits, write "RURAL")

(d) Street No. 618 School (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME John Harold Tucker

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male

5. Color or race W

6. (a) Single, widowed, married, divorced Mr.

6. (b) Name of husband or wife Jeanne Dance

6. (c) Age of husband or wife if alive year

7. Birth date of deceased 10-17-1897 (Month) (Day) (Year)

8. AGE: Years 43 Months 10 Days 18 If less than one day hr. min.

9. Birthplace Jeff C. (City, town, or county) Mo. (State or foreign country)

10. Usual occupation Auditor

11. Industry or business

MOTHER FATHER

12. Name Chas.

13. Birthplace New York (City, town, or county) (State or foreign country)

14. Maiden name Mary D. Dyer

15. Birthplace Davenport Iowa (City, town, or county) (State or foreign country)

16. (a) Informant Jeanne Dance Tucker

(b) Address Jeff City

17. (a) (Burial, cremation, or removal) (b) Date thereof 9-2-41 (Month) (Day) (Year)

(c) Place: burial or cremation Jeff C.

18. (a) Signature of funeral director Walbert Hodge

(b) Address

19. (a) 9-2- (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 30 year 1941 hour 10:30 minute A. M.

21. I hereby certify that I attended the deceased from , 19, to , 19; that I last saw him alive on , 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to 94 a	
Due to 94 b	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature F. R. Brandt (M. D. or other)

Address Date signed

SUPPLEMENTARY

29727