S. No. 2
OM—2-43
v. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 7 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 26217

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7645

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: City Sanitarium 0 (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7 months (Specify whether
In this community 9 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000 21
(c) City or town St Louis 17 (If outside city or town limits, write "RURAL")
(d) Street No. 117 N. Cardinal (If rural, give location) 7
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME DELIA TUCKER

3. (b) If veteran, name war --

3. (c) Social Security No.

4. Sex female 3

5. Color or race negro

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

6. (b) Name of husband or wife Cal Tucker

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

7. Birth date of deceased ~~August~~ (Month) 7- 28- 1905 (Day) (Year)

8. AGE: Years 41 ~~37~~ Months ~~0~~ Days If less than one day hr. min.

9. Birthplace not known (City, town, or county) Tenn. (State or foreign country)

10. Usual occupation Housework

11. Industry or business ------

FATHER
12. Name not known
13. Birthplace not known (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name not known
15. Birthplace not known (City, town, or county) 9 (State or foreign country)

16. (a) Informant Thelma Singler
(b) Address 5400 Arsenal St

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 9-1-45 (Month) (Day) (Year)
(c) Place: burial or cremation E. St. Louis, Ill.

18. (a) Signature of funeral director C. L. Nash
(b) Address 111 N. 13th St

19. (a) SEP 1 1945 (Date received local registrar) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 29 year 1945 hour 12:15 minute P. M.

21. I hereby certify that I attended the deceased from Jan., 23, 1945 19 , to August 29 1945 that I last saw her alive on August 29 1945 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
General Paresis	1 yrx.
Due to 30	
Due to	
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 10

23. Signature L. Kerschbaumer M. D. (M. D.)
Address 5400 Arsenal St Date signed

(Licensed Embalmer's Statement on Reverse Side)

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.....C. T. Nash.....

Licensed Embalmer No.....2432.....

P. O. Address.....111 Main St.....

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, fact should be so stated above.