

S. No. 2
A-12-45
v. 5-17-39
X47070

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 38477
4997
Registrar's No.

FILED DEC 9 1947
Registration District No. 149

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:
St. Marys Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 46 days
(Specify whether years, months or days)
In this community Greater K.C. 50 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Kansas (b) County Wyandotte 999
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 2733 N 11th St.
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country.

3. (a) PRINT FULL NAME Evelyn May Tucker
(b) If veteran, name war no
(c) Social Security No. No

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 11 day 26
year 1947 hour 11 minute 45 A. M.
21. I hereby certify that I attended the deceased from 3-7-1940
to 11-26-1947
that I last saw her alive on 11-26 1947
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife William J. Tucker
6. (c) Age of husband or wife if alive years
7. Birth date of deceased 12-4-1858
(Month) (Day) (Year)

Immediate cause of death Carcinoma Common + cystic bile ducts.
Due to Unknown cause

8. AGE: Years Months Days If less than one day
88 11 22 hr. min.

Due to Unknown cause
Other conditions Provisional America
(Include pregnancy within 3 months of death).

9. Birthplace Cooper Co. Mo.
(City, town, or county) (State or foreign country)
10. Usual occupation At Home

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

MOTHER FATHER
11. Industry or business
12. Name George Edward Chambers
13. Birthplace Cooper Co. Mo.
(City, town, or county) (State or foreign country)
14. Maiden name Sarah Byler
15. Birthplace Mo. 17
(City, town, or county) (State or foreign country)

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?

16. (a) Informant Miss Alice Chambers
(b) Address 2928 Forest, K.C. Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-28-47
(Month) (Day) (Year)
(c) Place: burial or cremation Mt. Washington
18. (a) Signature of funeral director Gibson & Son
(b) Address 646 State Ave K.C. Kansas
19. (a) 11-28-47 (Date received local registrar)
(b) Alvantine Holmes (Registrar's signature)

While at work? (Specify type of place) (c) Means of injury
23. Signature [Signature] (M. D. or other)
Address 1115 3rd Street, Kansas City Date signed 11/26/47

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

George M. Maloney

Licensed Embalmer No. *8798*

P. O. Address *K. O. Nauyas*

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.