No. 2
-1/47
-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED DEC 22 1947

Registration District No. 377

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 6076

State File No. 43876

Registrar's No. 2559

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution: Robert Koch Hospital 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 18 days. (Specify whether
In this community 3 years.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County ARO

(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")

(d) Street No. 3927 Aldine 9
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 1

If yes, name country

3. (a) PRINT FULL NAME James E. Tucker

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

3. (c) Social Security No.

4. Sex M 2

5. Color or race Negro

6. (a) Single, widowed, married, divorced Single 0

6. (b) Name of husband or wife —

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

7. Birth date of deceased Jan. (Month) 1 (Day) 1926 (Year)

8. AGE:

Years	Months	Days	If less than one day
21	11	11	— hr. — min.

9. Birthplace Aberdeen, Mississippi 1
(City, town, or county) (State or foreign country)

10. Usual occupation Odd jobs

11. Industry or business Independent Packing Co.

FATHER
12. Name Wm Tucker 9
13. Birthplace ? (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Soda McDown
15. Birthplace Mississippi 1
(City, town, or county) (State or foreign country)

16. (a) Informant Hospital Records
(b) Address Robert Koch Hospital

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/16/47 (Month) (Day) (Year)
(c) Place: burial or cremation ~~National~~ Greenwood Cemetery

18. (a) Signature of funeral director Ellis Funeral Home
(b) Address 2820 S Toddard St

19. (a) 12-13-47 (Date received local registrar) (b) [signature] (Registrar's signature) MSN

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 12
year 1947 hour 5 10 minute A M.

21. I hereby certify that I attended the deceased from 11-25, 1947, to 12-12, 1947, that I last saw h..... alive on ....., 19.....
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Pulmonary Tuberculosis	3½ Mos?
Due to	
Due to 13 b	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN

Underline the cause of 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 0

23. Signature William C Santon II (M. D. ~~or other~~)
Address Robert Koch Hospital Date signed 12-12-47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

OCT 1948

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 Fulton E Culkin

Licensed Embalmer No. 498

P. O. Address St Louis 13, Mo

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.