

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **10648**
Registrar's No. **2584**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo. 2249	
d. FULL NAME OF HOSPITAL OR INSTITUTION 5914 Nashville Ave.		d. STREET ADDRESS (If rural, give location) 3020a Iowa Ave.	

3. NAME OF DECEASED (Type or Print): a. (First) Alta b. (Middle) Mary c. (Last) Stuckey	4. DATE OF DEATH (Month) (Day) (Year) March 17, 1952
--	---

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH October 18, 1887	9. AGE (In years last birthday) 64 If under 1 year: Months 4 Days 29	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Pinckneyville, ILL.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
----------------------	-------------------------------	---	--	--	--	-----------------------------------	---	---

13a. FATHER'S NAME Robert Mc Cune	13b. MOTHER'S MAIDEN NAME Rachel Smith	14. NAME OF HUSBAND OR WIFE Daniel Stuckey
---	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Daniel M. Stuckey	ADDRESS 3020 A Iowa Ave.
--	-------------------------	---	------------------------------------

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic myocarditis		1 year
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Chronic cholecystitis DUE TO (c)		4 months
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
------------------------	----------------------------------	--

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? H22.2

22. I hereby certify that I attended the deceased from **4-2-52**, 19**52**, to **3-17-52**, 19**52**, that I last saw the deceased alive on **3-17-52**, and that death occurred at **6:50a** m., from the causes and on the date stated above.

23a. SIGNATURE [Signature]	23b. ADDRESS 2840 California	23c. DATE SIGNED 3-17-52
--------------------------------------	--	------------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 3/20/52	24c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.
---	-----------------------------	--	---

DATE REC'D BY LOCAL REG. MAR 19 1952	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE John H. Gebken	ADDRESS Sons 2630 Gravois Ave.
--	---	---	--

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

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Robert F. Gubker

Licensed Embalmer No. 4144

P. O. Address 2630 Gravois Ave.

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.