No. 300 FILED APR 22 1952
10-48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 11978

BIRTH NO. _____ REG. DIST. NO. 31 PRIMARY REG. DIST. NO. 4040 Registrar's No. 15

80
1

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

1. PLACE OF DEATH
a. COUNTY: Benton
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Cole Camp
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ---

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Benton 0080
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Cole Camp 0
d. STREET ADDRESS (If rural, give location): ---

3. NAME OF DECEASED (Type or Print)
a. (First): Lillian
b. (Middle): Orlive
c. (Last): Tucker

4. DATE OF DEATH (Month) (Day) (Year): April 17th 1952

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Mar 27th 1859
9. AGE (In years last birthday): 93 — IF UNDER 1 YEAR: Months 0, Days 21 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): New York
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: Alonza Rouse
13b. MOTHER'S MAIDEN NAME: Unknown
14. NAME OF HUSBAND OR WIFE: A G Tucker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): ---
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S SIGNATURE OR NAME: A T Tucker — ADDRESS: Cole Camp Mo

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Essential Hypertension
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION: 332X
20. AUTOPSY? YES ☐ NO ☒

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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 1, 1952, *to* 4-17, 1952, *that I last saw the deceased alive on* 4-16, 1952, *and that death occurred at* 6:30 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): A. W. Moreland — Dll 2
23b. ADDRESS: Cole Camp Mo
23c. DATE SIGNED: 4-19-52

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial ( )
24b. DATE: Apr 20th 1952
24c. NAME OF CEMETERY OR CREMATORY: Cole Camp Cemetery
24d. LOCATION (City, town, or county) (State): Cole Camp Missouri

DATE REC'D BY LOCAL REG.: 4-19-52
REGISTRAR'S SIGNATURE: E L Eickhoff 3/4 0
25. FUNERAL DIRECTOR'S SIGNATURE: E E L Eickhoff — ADDRESS: Cole Camp Mo

(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 ..... Student Embalmer No. .....

working under my personal supervision.

Student .....
Student Embalmer

Signed E. L. Eckhoff

Licensed Embalmer No. 730

P. O. Address Cole Camp Mo

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

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