

STANDARD CERTIFICATE OF DEATH

State File No. **24231**

FILED JUL 28 1952

BIRTH NO. _____ REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **5465** Registrar's No. **702**

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

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Greene	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural N Campbell Twsp		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield 0396	
c. LENGTH OF STAY (In this place) 2 years		d. STREET ADDRESS (If rural, give location) 613 S Main	
d. FULL NAME OF HOSPITAL OR INSTITUTION County Hospital			
3. NAME OF DECEASED a. (First) KATE (Type or Print)		b. (Middle) FISKE	c. (Last) TUCKER
4. DATE OF DEATH (Month) (Day) (Year) July 23 1952			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed ✓	8. DATE OF BIRTH February 19, 1872
9. AGE (In years last birthday) 80	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 HR. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (City and State or Foreign Country) Springfield, Illinois	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME W H Fiske		13b. MOTHER'S MAIDEN NAME Savilla Bolinger	14. NAME OF HUSBAND OR WIFE ----
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Fay L. Milligan, Springfield, 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, asthma, etc. It means the disease, injury, or complication which caused death.		- MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Atherosclerosis, cerebral mental deterioration ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ 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	306x	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Jan 1951 , to July 23, 1952 , that I last saw the deceased alive on July 21, 1952 , and that death occurred at 7:30 P. m. , from the causes and on the date stated above.			
23a. SIGNATURE James R. Ames M.D.		23b. ADDRESS Springfield, Mo.	23c. DATE SIGNED 7/26/52
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE July 26, 1952	24c. NAME OF CEMETERY OR CREMATORY Maple Park	24d. LOCATION (City, town, or county) (State) Springfield, Missouri
DATE REC'D BY LOCAL REG. 7-26-52	REGISTRAR'S SIGNATURE Edith Williamson Registrar	25. FUNERAL DIRECTOR'S SIGNATURE Alma Johnson	ADDRESS Springfield, Mo.

AUG 11 1952

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: Bernard F. Wright

Licensed Embalmer No. 42 93

P. O. Address Springfield

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.