

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34197
State File No. 4605

FILED NOV 5 - 1954

| | | | | | | | |
|--|--|--|---|---|--|---|--|
| BIRTH NO. _____ | | REG. DIST. NO. <u>149</u> | | PRIMARY REG. DIST. NO. <u>1002</u> | | Registrar's No. <u>4605</u> | |
| 1. PLACE OF DEATH a. COUNTY <u>Jackson</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>Jackson</u> | | | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u> | | c. LENGTH OF STAY (In this place) <u>10yrs</u> | | c. CITY OR TOWN <u>Kansas City</u> | | d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>3215 Homes HOLMES</u> | | | | STREET ADDRESS (If rural, give location) <u>49 3215 Homes HOLMES. 3448</u> | | | |
| 3. NAME OF DECEASED (Type or Print) <u>Myrtle M Tucker</u> | | | a. (First) <u>Myrtle</u> b. (Middle) <u>M</u> c. (Last) <u>Tucker</u> | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>Sept 29 1954</u> | |
| 5. SEX - <u>Fm</u> | | 6. COLOR OR RACE <u>Wh</u> | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow 2</u> | | 8. DATE OF BIRTH <u>Mar 26 1873</u> | |
| 9. AGE (In years last birthday) <u>81</u> | | IF UNDER 1 YEAR Months _____ Days _____ | | IF UNDER 1 HRS. Hours _____ Min. _____ | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>O.P.A</u> | | 11. BIRTHPLACE (City and State or Foreign Country) <u>Clinton Mo</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>Usa</u> | | | | | | | |
| 13a. FATHER'S NAME <u>Charles Duncan</u> | | | 13b. MOTHER'S MAIDEN NAME <u>Margaret Yates</u> | | | 14. NAME OF HUSBAND OR WIFE <u>Deceased</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Celia Romine 3215 Homes K.C. Mo</u> | | | |
| 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, ashenia, etc. It means the disease, injury, or complication which caused death. | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>Acute Myocardia With Cardiac Failure</u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> | | | |
| ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO <u>Chronic Cardiac Failure myocardial degenerative failure</u> | | | | <u>3 mo</u> | | | |
| DUE TO <u>Chronic Heart Disease with senility</u> | | | | <u>1 yr</u> | | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | | <u>4222</u> | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION <u>✓</u> | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>✓</u> | | 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) <u>✓</u> | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? <u>✓</u> | | | |
| 22. I hereby certify that I attended the deceased from <u>Sept - 1953</u> , to <u>Sept 29, 1954</u> , that I last saw the deceased alive on <u>Sept 29, 1954</u> , and that death occurred at <u>4:50 p m.</u> , from the causes and on the date stated above. | | | | | | | |
| 23a. SIGNATURE <u>Frederick C. Lamar</u> (Degree or title) <u>M.D.</u> | | | | 23b. ADDRESS <u>624 Professional Bldg</u> | | 23c. DATE SIGNED <u>Sept 29-54</u> | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24b. DATE <u>Oct 1 1954</u> | | 24c. NAME OF CEMETERY OR CREMATORY <u>Grain Valley</u> | | 24d. LOCATION (City, town, or county) (State) <u>Grain Valley Mo</u> | |
| DATE REC'D BY LOCAL REG. <u>10-1-54</u> | | REGISTRAR'S SIGNATURE <u>Neva Marshall</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Webb Funeral Home Blue Springs Mo</u> | | | |

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

File
No 1020

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was emb

by me, or by Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *R. Bluhdt*

Licensed Embalmer No. ²³⁵~~250~~

P. O. Address *Blue Springs*

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

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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