

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34053

STATE FILE NUMBER

FILED OCT 1 - 1956

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 872

1. PLACE OF DEATH a. COUNTY <u>GREENE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> COUNTY <u>GREENE</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>SPRINGFIELD</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>SPRINGFIELD</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1212 W. LOMBARD 50 Ws.</u>		Length of stay in lb	d. STREET ADDRESS (If outside, give location) <u>1000 S. FORT</u>

3. NAME OF DECEASED (Type or print) First <u>LLOYD</u> Middle <u>TUCKNESS</u> Last <u>TUCKNESS</u>			4. DATE OF DEATH Month <u>SEPT.</u> Day <u>24</u> Year <u>1956</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6 Dec. 1890</u>	9. AGE (In years last birthday) <u>65</u>	IF UNDER 1 YEAR Months <u>6</u> Days <u>5</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Custodian</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Children's Name</u>		11. BIRTHPLACE (City and state or country) <u>Missouri</u>	
13. FATHER'S NAME <u>Albert Tuckness</u>			14. MOTHER'S MAIDEN NAME <u>Ola Fullerton</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO.</u>		17. INFORMANT <u>Edna Tuckness</u> Address <u>Spngfld. Mo.</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>S.P.</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour <u>6:00</u> Month <u>Sept.</u> Day <u>24</u> Year <u>1956</u> a. m. <u>P.M.</u> p. m.			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE

21. I attended the deceased from _____ to Sept. 24-56 and last saw her alive on Sept. 24, 1956
Death occurred at 6:00 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>C E Feller MD</u> (Degree or title)	22b. ADDRESS <u>609 Cherry, Springfield, Mo.</u>	22c. DATE SIGNED <u>9-25-56</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>9-26-56</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn</u>	23d. LOCATION (City, town, or county) (State) <u>Springfield, Mo.</u>
24. FUNERAL DIRECTOR <u>JW Klingner & Co.</u> ADDRESS <u>Spngfld. Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>9-27-56</u>	26. REGISTRAR'S SIGNATURE <u>F. W. Williamson</u>	

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare, Public Service
300 1-56
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.....
Signature of Student Embalmer

Signed.....
W. M. Rhodes

Licensed Embalmer No.....
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P. O. Address.....
Springfield

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If 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.