

FILED AUG 19 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30105

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's **6733**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis ✓	
b. CITY (If outside corporate limits, give TOWNSHIP only) Inside Limits OR TOWN ST. LOUIS, MISSOURI Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Robertson 4000 Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) Length of stay in lb 04 HOSPITAL OR INSTITUTION BARNES HOSPITAL		d. STREET ADDRESS R.R. # 2, Box 168 (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ELVEN Middle FRANCES Last TUCKER			4. DATE OF DEATH Month JULY Day 17 Year 1957
5. SEX Male <input type="checkbox"/>	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 20, 1909 47
9. AGE (In years last b'rt/Day) 47		IF UNDER 1 YEAR Mo 10 Day 17 Hour Min. 	IF UNDER 24 HRS. Mo Day Hour Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) tool & die maker		10b. KIND OF BUSINESS OR INDUSTRY Wagner Electric	11. BIRTHPLACE (City and state or country) Madison, Illinois ✓
12. CITIZEN OF WHAT COUNTRY? U.S.S.		13. FATHER'S NAME Sewell Tucker	
14. MOTHER'S MAIDEN NAME Della Bond		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no no	
16. SOCIAL SECURITY NO. 498-07-1547		17. INFORMANT Address Mrs. Della Tucker, R.R. 2, Robertson, M	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DISSEMINATED LYMPHOEPTHELIOMA			INTERVAL BETWEEN ONSET AND DEATH 2 YRS.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 148X			
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 _____ Month _____ Day _____ Year _____ a. m. _____ 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 JULY 5, 1957 to JULY 17, 1957 and last saw ^{her} him alive on JULY 17, 1957 Death occurred at 12:35 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE F.R. Bradley M.D.		22b. ADDRESS BARNES HOSPITAL	22c. DATE SIGNED 7/17/57
23a. BURIAL, CREMATION, REMOVAL <input checked="" type="checkbox"/>	23b. DATE July 20, 1957	23c. NAME OF CEMETERY OR CREMATORY Oak Grove Cemetery	23d. LOCATION (City, town, or county) (State) Saint Charles, Mo.
24. FUNERAL DIRECTOR ADDRESS D. C. Dalloway, St. Charles, Mo.		25. DATE RECD. BY LOCAL REG. JUL 19 1957	26. REGISTRAR'S SIGNATURE J. Earl Smith, M.D. m. j. 13

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

(Licensed Embalmer's Statement on Reverse Side)

2000

2001

218

APR 18 1958

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 *Frank R. Amalson*

Licensed Embalmer No. 4

P. O. Address *St. Ch...*

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.