

FILED OCT 21 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38258
STATE FILE NUMBER
9224

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

9224

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
 MEDICAL CERTIFICATION

| | | | | | |
|--|--|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE | | b. COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | c. CITY OR TOWN | |
| ST. LOUIS, MISSOURI | | Yes <input type="checkbox"/> No <input type="checkbox"/> | | Mo. J.V. ROY 2269 | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION | | Length of stay in lb | | d. STREET ADDRESS (If outside, give location) | |
| 01 824 N. BEAUNE | | 26 | | 824 N. BEAUNE | |
| 3. NAME OF DECEASED (Type or print) | | | 4. DATE OF DEATH | | |
| First JESSE | | | Month SEPT. 5, 1957 | | |
| Middle W. | | | Day 5, 1957 | | |
| Last TUCKER | | | Year 1957 | | |
| 5. SEX & COLOR OR RACE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> 3 DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH | |
| Male White | | | | 3-26-1890 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) | |
| Employed | | Laborer | | Mid. Tex. | |
| 13a. FATHER'S NAME | | 13b. MOTHER'S MAIDEN NAME | | 14. NAME OF HUSBAND OR WIFE | |
| George W. Tucker | | Mary Susan Williams | | May Tetterson Tucker | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give no. of years of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address | |
| Yes | | | | May Tetterson 2309 Goddard St | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| IMMEDIATE CAUSE (a) EPIDERMOID CARCINOMA OF ALVEOLAR RIDGE WITH METASTASES | | | 9 MOS. | | |
| DUE TO (b) Conditions, if any, which have led to above cause (a), stating the underlying cause of last. | | | | | |
| 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 checked="" type="checkbox"/> | | |
| 20b. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | | | 20e. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART-II of item 18.) | | |
| 20c. TIME OF INJURY Hour a.m. p.m. | | | 144x | | |
| 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 | |
| | | | | St. Louis, Mo. | |
| 21. I attended the deceased from FEB. 18, 1957 to APRIL 3, 1957 and last saw her alive on APRIL 3, 1957 Death occurred at 6:30 P.M. 9/5/57 m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE C. D. Vermillion, M.D. | | | 22b. ADDRESS BARNES HOSPITAL | | 22c. DATE SIGNED 9/23/57 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE OCT 31 57 | 23c. NAME OF CEMETERY OR CREMATORY Anatomical Board | | 23d. LOCATION (City, town, or county) (State) St. Louis, Mo. |
| 24. FUNERAL DIRECTOR Rowland-Aker Mortuary Service 4104 Manchester Ave St. Louis 10, Mo. | | | 25. DATE RECD. BY LOCAL REG. OCT 3 57 | | 26. REGISTRAR'S SIGNATURE J. Carl Smith mo m 83 |

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

Licensed Embalmer No.

P. O. Address

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 embalmed by a **STUDENT**, he also shall sign in his **OWN** handwriting.
If this body is not embalmed, fact should be so stated above.