

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-015451  
STATE FILE NUMBER

FILED APR 29 1958

Registration District No. 316 Primary Registration District No. 3061 Registrar's No. 152

300  
1-57  
0942

1. PLACE OF DEATH a. COUNTY <u>ST. FRANCOIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>ST. FRANCOIS</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>FLAT RIVER</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>FLAT RIVER</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		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <u>603 W. MAIN</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>EUA</u> Middle <u>L.</u> Last <u>TUCKER</u>			4. DATE OF DEATH Month <u>April</u> Day <u>17</u> Year <u>1958</u>		
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5. SEX <u>FEMALE</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>NOV 6, 1893</u>	9. AGE (In years last birthday) <u>64</u> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____	
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>BENT CO, MO</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>
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13a. FATHER'S NAME <u>JAMES LEE</u>		13b. MOTHER'S MAIDEN NAME <u>SARAH SPAW</u>	14. NAME OF HUSBAND OR WIFE <u>D.L. TUCKER</u>
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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 <u>Mrs. D.L. Tucker</u> Address <u>Flat River, Mo.</u>
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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>Lympho-sarcoma (general)</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____	2001
	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"/>

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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____
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20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 _____
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21. I attended the deceased from May 1957 to April 1958 and last saw her alive on 4-5-58  
Death occurred at 7:30 P. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>W. Gaele M.D.</u> (Degree in _____)	22b. ADDRESS <u>Deerage Mo</u>	22c. DATE SIGNED <u>4-18-58</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>4-20, 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST. FRANCOIS MEMPHIS</u>	23d. LOCATION (City, town, or county) (State) <u>BARNETT MO.</u>
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24. FUNERAL DIRECTOR <u>Raymond Caldwell and Son</u> ADDRESS <u>Flat River, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Apr. 18, 1958</u>	26. REGISTRAR'S SIGNATURE <u>Ether Rudloff</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

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.

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 Paul D. Deval

Licensed Embalmer No. 4120  
P. O. Address Farmington, N.H.

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.