

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-029954

STATE FILE NUMBER

FILED SEP 5 1958 Registration District No. 290 Primary Registration District No. 5986 Registrar's No. 136

1. PLACE OF DEATH a. COUNTY Pulaski		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Pulaski	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Swedeborg, Missouri		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Swedeborg, Missouri 6850
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION None.		Length of stay in 1b 2 yrs.	d. STREET ADDRESS (If outside, give location) None.
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Arch. Middle L. Last Tucker.			4. DATE OF DEATH Month Aug. Day 29, Year 1958		
---	--	--	---	--	--

5. SEX Male	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 Sept. 4, 1887	9. AGE (In years last birthday) 70	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>
-----------------------	-----------------------------------	---	--	--	---	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter.	10b. KIND OF BUSINESS OR INDUSTRY retired.	11. BIRTHPLACE (City and state or country) Richland, Missouri	12. CITIZEN OF WHAT COUNTRY? USA
--	--	---	--

13a. FATHER'S NAME Daniel. Tucker.	13b. MOTHER'S MAIDEN NAME Kaziah Saltsman.	14. NAME OF HUSBAND OR WIFE Sadie Olive Tucker.
--	--	---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.	16. SOCIAL SECURITY NO. Unknown.	17. INFORMANT Sadie O. Tucker.	Address Swedeborg, Missouri
---	--	--	---------------------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Status Asthmaticus		INTERVAL BETWEEN ONSET AND DEATH 2 HRS.	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Myocardial HEART disease		6 MO.
	DUE TO (c) 4222		
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.) ✓
---	--

20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>	20d. INJURY OCCURRED WHILE AT <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 Swedeborg, Missouri	COUNTY Pulaski	STATE Missouri
--	---	--	--	--------------------------	--------------------------

21. I attended the deceased from _____, to _____, and last saw her/him alive on _____ Death occurred at 1:30 A on the date stated above; and to the best of my knowledge, from the causes stated.	
---	--

22a. SIGNATURE John A. Mikolovich (Degree or title) D.O.	22b. ADDRESS Crocker, Missouri	22c. DATE SIGNED 8/29/58
---	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 8/31/58	23c. NAME OF CEMETERY OR CREMATORY Bethlehem. Cemetery	23d. LOCATION (City, town, or county) (State) Swedeborg, Missouri
--	-----------------------------	--	---

24. FUNERAL DIRECTOR'S ADDRESS Hedges Funeral Home Crocker, Mo	DATE RECD. BY LOCAL REG. 8-30-58	25. REGISTRAR'S SIGNATURE Paula Ann Anderson
--	--	--

300
1-57

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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 *Clarence Moss*

Licensed Embalmer No. *4896*

P. O. Address *Waynesville, N.C.*

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.