

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-001550

STATE FILE NUMBER

FILED JAN 21 1959

Registration District No. 149 Primary Registration District No. 1002

Registrar's No. 82

300  
-57

|   |                                  |   |  |  |   |
|---|----------------------------------|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Jackson</b>   |                                  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b> |  |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>Kansas City</b>   |                                  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | c. CITY OR TOWN <b>Kansas City</b>   |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>              |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>5204 Saida</b>  |                                  | Length of stay in lb<br><b>16 yrs.</b>  | d. STREET ADDRESS (If outside, give location)<br><b>5204 Saida</b>   |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>             |
| 3. NAME OF DECEASED (Type or print)<br>First <b>IRVINE</b> Middle <b>SPANE</b> Last <b>TUCKER</b>   |                                  |   | 4. DATE OF DEATH<br>Month <b>Jan.</b> Day <b>5,</b> Year <b>1959</b>   |  |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Feb. 26, 1887</b>   | 9. AGE (In years last birthday)<br><b>71</b>                                     | IF UNDER 1 YEAR<br>Months Days Hours Min.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Dental Tech.</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Dentistry</b>   | 11. BIRTHPLACE (City and state or country)<br><b>Cooper County, Mo.</b>  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                    |   |
| 13a. FATHER'S NAME<br><b>Wm. Tucker</b>   |                                  | 13b. MOTHER'S MAIDEN NAME<br><b>Unknown</b>   |  | 14. NAME OF HUSBAND OR WIFE<br><b>Ora Lee Cooper Tucker</b>                      |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)<br><b>Yes W.W. I</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>495-20-3811</b>   | 17. INFORMANT Address<br><b>Ora Tucker, 5204 Saida, Kansas City, Mo.</b>   |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b>                          |                                  |   |  |  | INTERVAL BETWEEN ONSET AND DEATH  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) _____<br>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?<br>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<br>Hour _____ Month, Day, Year _____<br>a.m. _____ p.m. _____   |                                  |   |  |  |   |
| 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   |  | COUNTY STATE  |
| 21. I attended the deceased from _____ to _____ and last saw her alive on _____<br>Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated. |                                  |   |  |  |   |
| 22a. SIGNATURE<br><i>Hugh H. Owens</i> (Degree or title)  |                                  | 22b. ADDRESS<br><i>1034 Beatty Blvd</i>   |  | 22c. DATE SIGNED<br><i>1-6-59</i>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE<br><b>1-8-59</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Washington Cem.</b>   | 23d. LOCATION (City, town, or county) (State)<br><b>Kansas City 22, Missouri</b> |   |
| 24. FUNERAL DIRECTOR<br><b>Geo. C. Carson &amp; Sons, Indep., Mo.</b>   |                                  | 25. DATE RECD. BY LOCAL REG.<br><b>1-6-59</b>   |  | 26. REGISTRAR'S SIGNATURE<br><i>Neva Marshall</i>                                |   |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Hugh H. Owens

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 *Dean W. Huff* .....

Licensed Embalmer No. *4914* .....

P. O. Address *Indy, Mo.* .....

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.