

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-002651
STATE FILE NUMBER

Registration District No. 316 Primary Registration District No. 6075 Registrar's No. 28

FILED FEB 3 1959

1. PLACE OF DEATH
a. COUNTY St. Francois

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Phelps

b. CITY (If outside corporate limits, give TOWNSHIP only)
OR TOWN St. Francois Township Inside Limits Yes No

c. CITY OR TOWN Rolla 68120 Inside Limits Yes No

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION State Hospital # 4 Length of stay in lb 15y, 10m, 13day d. STREET ADDRESS (If outside, give location) Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First Middle Last
CORA TUCKER

4. DATE OF DEATH Month Day Year
January 16, 1959

5. SEX female 6. COLOR OR RACE white 7. MARRIED NEVER MARRIED WIDOWED DIVORCED 8. DATE OF BIRTH About 1914 9. AGE (In years last birthday) Abt. 44 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (City and state or country) Missouri 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Fred B. Tucker 13b. MOTHER'S MAIDEN NAME Lula Logan 14. NAME OF HUSBAND OR WIFE None

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. none 17. INFORMANT Address Records State Hospital # 4 - Farmington, Mo.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Far advanced pulmonary tuberculosis, bilateral as-revealed by-x-ray-about-5-years-ago. INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____
DUE TO (c) _____

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
Mental Deficiency. 19. WAS AUTOPSY PERFORMED? YES NO

20a. ACCIDENT SUICIDE HOMICIDE 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 NOT WHILE AT WORK 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 March 3, 1943 to Jan. 16, 1959 and last saw her ^{her} alive on Jan. 16, 1959
Death occurred at 7:50 P. M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) [Signature] 22b. ADDRESS State Hospital No. 4 Farmington, Missouri 22c. DATE SIGNED 1-16-59

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal 23b. DATE Jan. 24, 1959 23c. NAME OF CEMETERY OR CREMATORY Washington Univ. Anat. Dept. 23d. LOCATION (City, town, or county) (State) St. Louis, Missouri

24. FUNERAL DIRECTOR ADDRESS Cozean Funeral Home, Farmington, Mo. 25. DATE RECD. BY LOCAL REG. Jan. 29, 1959 26. REGISTRAR'S SIGNATURE [Signature]

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 ^{partially} ~~embalmed~~
by me, or by James M. Leahy Student Embalmer No.

working under my personal supervision.

NOT EMBALMED

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.