

Health, Welfare
Public Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-003885

STATE FILE NUMBER

FILED FEB 10 1959

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 299

300
-57

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Richmond Heights		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Ferguson 4000
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Marys Hospt		Length of stay in lb 10 Days	d. STREET ADDRESS (If outside, give location) 30 Oliver
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First Mary Middle B. Last Tucker			4. DATE OF DEATH Month 1 Day 28 Year 59			
----------------------------------------------------------------------------------------------	--	--	-----------------------------------------------------------------	--	--	--

5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-26-1881	9. AGE (In years last birthday) 77	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
-------------------------	----------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------	--------------------------------------	----------------------------------------------	---------------------------	--------------------------	-------	------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (City and state or country) St. Louis, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
------------------------------------------------------------------------------------------------------------------	------------------------------------------------------	--------------------------------------------------------------------------	-----------------------------------------------

13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Deceased
--------------------------------------	---------------------------------------------	------------------------------------------------

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 Mr. & Mrs. Robt. Anslyn 9415 Ouburn
-----------------------------------------------------------------------------------------------------------------------	----------------------------------------	-------------------------------------------------------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) pulmonary embolism		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (c), stating the underlying cause last.	DUE TO (b) arteriosclerotic heart disease and	
	DUE TO (c) fat embolism due to fracture hip	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) fracture hip, left.		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 Month, Day, Year a.m. p.m. 1/18/59	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 400 COUNTY STATE
--------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------	------------------------------------------------------

21. I attended the deceased from 1/18/59 to 1/28/59 and last saw her alive on 1/28/59 Death occurred at 8:30 P. m on the date stated above; and to the best of my knowledge, from the causes stated.

22. SIGNATURE (Degree or title) Ronald O. Burst M.O.	22b. ADDRESS 16 Hampton Village Plaza	22c. DATE SIGNED 1/30/59
----------------------------------------------------------------	-------------------------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 1-31-1959	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis Co., Missouri
------------------------------------------------------------	-------------------------------	---------------------------------------------------------------------	---------------------------------------------------------------------------------

24. FUNERAL DIRECTOR ADDRESS Jos. W. Clark F.H. 1125 Hodiamont	25. DATE RECD. BY LOCAL REG. JAN 30 1959	26. REGISTRAR'S SIGNATURE John C. Murphy M.D.
--------------------------------------------------------------------------	----------------------------------------------------	---------------------------------------------------------

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

13678

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 *Laurence P. Harding*

Licensed Embalmer No. *4979*
P. O. Address *St. Louis*

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.