

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-007728
STATE FILE NUMBER
2 2039

FILED MAR 10 1959

Registration District No. _____ Primary Registration District No. _____ Registrar No. _____

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-57

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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DePaul Hospital		d. STREET ADDRESS (If outside, give location) 2543a E. University St	
3. NAME OF DECEASED (Type or print) First Middle Last GEORGE TUCKER		4. DATE OF DEATH Month Day Year Feb. 25 1959	
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 Nov. 25, 1906
9. AGE (In years last birthday) 52		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur	11. BIRTHPLACE (City and state or country) St. Louis MO 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		10b. KIND OF BUSINESS OR INDUSTRY Aalco Trucking CO	12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Dennis Tucker		13b. MOTHER'S MAIDEN NAME Mary Fury	14. NAME OF HUSBAND OR WIFE Hilda 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. 497-09-9360	17. INFORMANT Address Hilda Tucker 2543a E. University Street
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chondrosarcoma DUE TO (b) none DUE TO (c) none PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) none			INTERVAL BETWEEN ONSET AND DEATH don't know 199.1
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.		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 1-2-59 to 2-25-59 and last saw her alive on 2-24-59 Death occurred at 1 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Walter H. Sporenson M.D.		22b. ADDRESS 1515 St. Louis Avenue	
22c. DATE SIGNED 2-26-59		22d. DATE SIGNED 2-26-59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Feb. 27, 1959	
23c. NAME OF CEMETERY OR CREMATORY S.S. Peter & Paul Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis MO.	
24. FUNERAL DIRECTOR ADDRESS SUEDMEYER & SON'S 3934 N. 20th Street		25. DATE RECD. BY LOCAL REG. FEB 26 59	
26. REGISTRAR'S SIGNATURE Road Smith, M.D. mjb			

All diseases in Part I must be causally related.

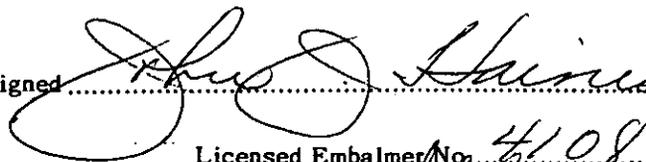
Use only BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 
Licensed Embalmer No. 4108
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.