

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-017412

FILED JUN 1 1959

Registration District No. 128

Primary Registration District No. 2000

STATE FILE NUMBER

Registrar's No. 529

|  |                                  |   |   |  |   |
|--|----------------------------------|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Greene</b>   |                                  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>Greene</b> |  |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br><b>Springfield</b>  |                                  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | c. CITY OR TOWN<br><b>Springfield Springfield</b>   |  | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>              |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>St. Johns Hospital</b>   |                                  | Length of stay in 1b<br><b>0</b>  | d. STREET ADDRESS (If outside, give location)<br><b>1841 W. Atlantic</b>  |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>             |
| 3. NAME OF DECEASED (Type or print)<br>First <b>WINNIE</b> Middle <b>VIRGINIA</b> Last <b>TUCK</b>   |                                  |   | 4. DATE OF DEATH<br>Month <b>May</b> Day <b>27</b> Year <b>1959</b>   |  |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>29 March 1874</b>  | 9. AGE (In years last birthday)<br><b>85</b>             |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>  | 11. BIRTHPLACE (City and state or country)<br><b>Missouri</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |
| 13a. FATHER'S NAME<br><b>Siminon Dodd</b>  |                                  | 13b. MOTHER'S MAIDEN NAME<br><b>Tryphlinia Thomas</b>   |   | 14. NAME OF HUSBAND OR WIFE<br><b>Deceased</b>           |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>No</b>  | 17. INFORMANT<br><b>Hospital Records</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>acute myocardial infarction</b>   |                                  |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>4d</b>   |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) <b>arteriosclerotic coronary thrombosis</b>   |                                  |   |   |  | <b>4d</b>   |
| DUE TO (c) <b>arteriosclerotic heart disease</b>   |                                  |   |   |  | <b>&gt;1yr</b>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>4/200</b>  |                                  |   |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input 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 _____ a.m. _____ p.m.<br>Month, Day, Year _____  |                                  |   |   |  |   |
| 20d. INJURY OCCURRED WHILE AT WORK <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<br>COUNTY _____ STATE _____ |   |
| 21. I attended the deceased from <b>1/23/59</b> to <b>5/27/59</b> and last saw her <b>live</b> on <b>5/26/59</b><br>Death occurred at <b>4:50</b> <b>A.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated. |                                  |   |   |  |   |
| 22a. SIGNATURE (Degree or title)<br><i>Andrew L. Harbison M.D.</i>   |                                  |   | 22b. ADDRESS<br><b>609m Cherry Springfield, Mo.</b>   |  | 22c. DATE SIGNED<br><b>5/28/59</b>  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 23b. DATE<br><b>5/29/59</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Greenlawn</b>  |  | 23d. LOCATION (City, town, or county) (State)<br><b>Springfield, Missouri</b>                     |
| 24. FUNERAL DIRECTOR<br><b>J.W. KLINGNER &amp; CO. SPRINGFIELD, MO.</b>  |                                  |   | 25. DATE RECD. BY LOCAL REG.<br><b>5-28-59</b>  | 26. REGISTRAR'S SIGNATURE<br><i>Effie S. Melton</i>      |   |

All diseases in Part I must be causally related.

ANDREW L. HARBISON 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 *Lacharme Hugues* .....

Licensed Embalmer No. *3719* .....  
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.