

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-017991

Health,  
Welfare  
Public  
Service

FILED JUN 9 1959

Registration District No. 149 Primary Registration District No. 1002

STATE FILE NUMBER 2136  
Registrar's No.

300  
1-57  
4

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY ST. CLAIR	
b. CITY (If outside corporate limits, give TOWNSHIP only) KANSAS CITY		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN COLLINS Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR LINWOOD NURSING HOME INSTITUTION 1900 LINWOOD BLVD.		Length of stay in 1b 4 months	d. STREET ADDRESS 0930 (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last FLOSSIE H TUCKER			4. DATE OF DEATH Month Day Year APRIL 28, 1959
5. SEX FEMALE	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 JULY 17, 1890
9. AGE (In years of last birthday) 68		10. UNDER 1 YEAR Months Days Hours Min.	11. UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY DOMESTIC	11. BIRTHPLACE (City and state or country) BATES COUNTY, MISSOURI
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13a. FATHER'S NAME FREDERICK H. NESTLERODE	
13b. MOTHER'S MAIDEN NAME ROSEANNA A. DUDLEY		14. NAME OF HUSBAND OR WIFE WALTER E. 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. none	17. INFORMANT Address 2040 SO. 10th. MRS. ESTHER E. HOOVER-KANSAS CITY, KANSAS
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO (b) arteriosclerosis and DUE TO (c) carcinomatosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 331XH			INTERVAL BETWEEN ONSET AND DEATH 2 days 4 years
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 1-1-59 to 4-28-59 and last saw her/him alive on 4-28-59 Death occurred at 4:15 A. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Frank Paul Laureanzana MD		22b. ADDRESS 428 S. white ave	
22c. DATE SIGNED 4-28-59		22d. (Degree or title)	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE 4 28 59	
23c. NAME OF CEMETERY OR CREMATORY BENJAMIN CEM		23d. LOCATION (City, town, or county) (State) AMORET, MO.	
24. FUNERAL DIRECTOR D. W. NEWCOMER'S SONS-KANSAS CITY, MO.		25. DATE RECD. BY LOCAL REG. 4-28-59	
26. REGISTRAR'S SIGNATURE neve munsell			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION  
Frank Paul Laureanzana

Doctor, coroner, etc. must use only standard momentary ink pen to record symptoms when related. 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 embalmed by me, or by ....., Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed *Harrison W. Johnson* .....

Licensed Embalmer No. *4889* .....

P. O. Address *T. C. 7/0* .....

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.