

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-020664

STATE FILE NUMBER

Health,
& Welfare
Public
Service

300
1-57

FILED JUL 1 1959 Registration District No. 59 Primary Registration District No. 4097 Registrar's No. 112

1. PLACE OF DEATH a. COUNTY <i>Cass</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MO</i> b. COUNTY <i>Cass</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Harrisonville mo</i>		c. CITY OR TOWN <i>Freeman</i>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Memorial Hospital 10 yrs.</i>		d. STREET ADDRESS (If outside, give location) <i>019 0</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>WILLIAM MORRIS TUCKER</i>			4. DATE OF DEATH Month Day Year <i>June 21-1959</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 5-1904</i>
9. AGE (in years last birthday) <i>55</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>School Teacher</i>	11. BIRTHPLACE (City and state or country) <i>Hardin mo.</i>
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13a. FATHER'S NAME <i>Thomas William Tucker</i>		13b. MOTHER'S MAIDEN NAME <i>Mary Frances Helm</i>	14. NAME OF HUSBAND OR WIFE <i>Edith Tucker</i>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>491-20-2241</i>	17. INFORMANT <i>Eleanor J. Tucker Independence, Mo.</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CONGESTIVE HEART FAILURE</i>			INTERVAL BETWEEN ONSET AND DEATH <i>4 WEEKS</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>SUBACUTE BACTERIAL ENDOCARDITIS</i>			<i>12 WEEKS</i>
DUE TO (c) <i>HEMOLYTIC STREPTOCOCCUS</i>			<i>12 WEEKS</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>OBESITY & DIABETES MELLITUS</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 WORK <input type="checkbox"/> 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 <i>APRIL 1959</i> to <i>JUNE 21 1959</i> and last saw him alive on <i>JUNE 21 1959</i> Death occurred at <i>3:30 PM</i> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>R. Moody MD</i> (Degree or title)		22b. ADDRESS <i>HARRISONVILLE MO</i>	22c. DATE SIGNED <i>6-21-59</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>June 24-1959</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Freeman Cemetery</i>
23d. LOCATION (City, town, or county) <i>Freeman</i>		(State) <i>MO</i>	
24. FUNERAL DIRECTOR <i>Geo. E. Meyers</i>		ADDRESS <i>Cleveland mo</i>	25. DATE RECD. BY LOCAL REG. <i>6-23-59</i>
26. REGISTRAR'S SIGNATURE <i>Mrs. Gray Sebrer</i>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

CASS COUNTY
HEALTH DEPARTMENT

APR 25 1980

CASS COUNTY
HEALTH DEPARTMENT

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 *Geo. E. Myers*

Licensed Embalmer No. 2517
P. O. Address Cleveland Mo

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.