

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-023478

STATE FILE NUMBER

Registration No. 5449

FILED JUL 3 1959

Registration District No.

Primary Registration District No.

Registration No.

S. 300
1-57

25
34

6

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Length of stay in 1b		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print)		First		Last	
ALBERT		TUCKER		4. DATE OF DEATH	
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH		9. AGE (In years last birthday)		10a. USUAL OCCUPATION (Give kind of work done in present and past the life even if retired)	
Mar. 24, 1912		117		10b. KIND OF BUSINESS OR RESTAURANT	
11. BIRTHPLACE (City and state or country)		12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME	
St. Louis, Mo.		USA		Robert Tucker	
13b. MOTHER'S MAIDEN NAME		14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
Tillie (unk)		Vivian		No	
16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	
Unk.		Vivian Tucker 7562 Amherst		Himmelsieck-Hilton Syndrome	
				Diabetes Mellitus	
				260+	
				PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	
				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT SUICIDE HOMICIDE		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>					
20c. TIME OF INJURY		20d. INJURY OCCURRED WHILE AT WORK			
Hour a.m. Month, Day, Year p.m.		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 1937 to 6-6-59 and last saw him alive on 6-5-59					
Death occurred at 8:00 AM on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE		22b. ADDRESS		22c. DATE SIGNED	
Carl J. Hen MD.		18th Hwy highway		6-6-59	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Rem.		6/8/59		Beth Hamedrosh Hagodol	
				23d. LOCATION (City, town, or county) (State)	
				Hague, Mo.	
24. FUNERAL DIRECTOR		25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE	
Berger Memorial 4715 McPherson		JUN 8 59		Carl Smith. M.D.	

7.8.13

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 *Quirio G. Quindang*
Licensed Embalmer No. *4829*.....
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.**