

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-023481

STATE FILE NUMBER

Registrar's **2 6041**

FILED JUL 7 1959

Registration District No. _____ Primary Registration District No. _____

S. 300
v. 1-57
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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		Length of stay in 1b 15 Yrs.	d. STREET ADDRESS (If outside, give location) 5610 Enright Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First JOHN Middle D. Last TUSSEY			4. DATE OF DEATH Month JUNE Day 24 Year 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. 4, 1882
9. AGE (In years last birthday) 76		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister (Retired)		10b. KIND OF BUSINESS OR INDUSTRY Salem Meth. Church	11. BIRTHPLACE (City and state or country) Faswell Indiana
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13a. FATHER'S NAME George W. Tussey	
13b. MOTHER'S MAIDEN NAME Lucinda E Brock		14. NAME OF HUSBAND OR WIFE Mathilda (Forgey) Tussey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. 493-40-6178	17. INFORMANT Address Mrs. Mathilda Tussey, 5610 Enright, St. Louis
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			INTERVAL BETWEEN ONSET AND DEATH 10 DAYS
DUE TO (b) CEREBRAL ARTERIOSCLEROSIS			2 YEARS
DUE TO (c) _____			331X
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 <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 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	COUNTY STATE
21. I attended the deceased from JUNE 13, 1959 to JUNE 24, 1959 and last saw her/him alive on JUNE 24, 1959 Death occurred at 12:30 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) C. Vermillion, M.D.	22b. ADDRESS BARNES HOSPITAL	22c. DATE SIGNED 6/24/59	
23a. BURIAL, CREMATION, REBURYAL (Specify) Removal	23b. DATE 6/27/59	23c. NAME OF CEMETERY OR CREMATORY Roselawn Memorial Gardens	23d. LOCATION (City, town, or county) (State) Festus, Mo.
24. FUNERAL DIRECTOR Vinyard Funeral Home, Inc, Festus Mo.		25. DATE RECD. BY LOCAL REG. JUN 26 '59	26. REGISTRAR'S SIGNATURE Earl Smith, M.D. <i>m 86.</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.

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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 Keith B. Vinyard

Licensed Embalmer No. 4976

P. O. Address Festus, 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.