

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
 ED VS JAN 18 1960

-60-001201

Registration District No. 128 Primary Registration District No. 37 Registrar's No. 37 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>GREENE</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>GREENE</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>SPRINGFIELD</u>		Length of stay in 1b <u>55 YRS.</u>	c. CITY OR TOWN <u>SPRINGFIELD</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ROUTE # 7 BOX # 429</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>ROUTE # 7 BOX # 429</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>FANNIE LOUISE TUCKNESS</u>			4. DATE OF DEATH Month Day Year <u>JAN. 9 1960</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3/7/98</u>	9. AGE (last birthday) <u>61</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>LEAD HILL, ARK.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>FRANK ROMAN</u>		13b. MOTHER'S MAIDEN NAME <u>NETTIE LEE</u>		14. NAME OF HUSBAND OR WIFE <u>JESS TUCKNESS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT Address <u>JESS TUCKNESS, RT # 7, SPFLD, MO.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypoxia</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					
DUE TO (b) <u>Tracheal obstruction</u>					<u>3 mo</u>
DUE TO (c) <u>Cancer of thyroid, Papillary Adeno</u>					<u>1 yr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					PART II. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input 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 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 <u>11/4/59</u> to <u>1/9/60</u> and last saw her alive on <u>1/2/60</u> Death occurred at <u>7:45 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Gene P. Decker, M.D.</u>			22b. ADDRESS <u>406 B Prof Bldg.</u>		22c. DATE SIGNED <u>1/14/60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>1/14/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>EASTLAWN</u>		23d. LOCATION (City, town, or county) (State) <u>SPRINGFIELD, MO.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>H.H. LOHMEYER, SPRINGFIELD, MO.</u>			25. DATE RECD. BY LOCAL REG. <u>1-13-60</u>	26. REGISTRAR'S SIGNATURE <u>Effie S. Drutton</u>	

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

MS MAR 1 7 1961

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed HA Mc Cann

Licensed Embalmer No. 2727

P. O. Address Springfield

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.