

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) St. Louis		Length of stay in 1b	c. CITY OR TOWN St. Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Sarah and Cook Church of God in Christ		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 4605a Maffitt Ave.

3. NAME OF DECEASED (Type or print) First VERNELL Middle TUCKER Last TUCKER			4. DATE OF DEATH Month August Day 23 Year 1960			
5. SEX Male	6. COLOR OR RACE Negro	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2/14/99	9. AGE (last birthday) 61	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Porter		10b. KIND OF BUSINESS OR INDUSTRY St. Louis U. Anatomical Board		11. BIRTHPLACE (City and state or country) Forrest City, Ark. U. S. A.	12. CITIZEN OF WHAT COUNTRY	
13a. FATHER'S NAME Lawrence Tucker		13b. MOTHER'S MAIDEN NAME Maria Estes		14. NAME OF HUSBAND OR WIFE Blanche 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.		17. INFORMANT Address Blanche Tucker 4605a Maffitt		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Cardiac Infarct			15 min.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Coronary Heart Disease		5 month
	DUE TO (c) Arteriosclerosis		2 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 420.1			PART III. 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 checked="" 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 5:00 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 6/13/60 to 8/23/60 and last saw him alive on 8/23/60 Death occurred at 5:00 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) William M.D.		22b. ADDRESS 4701 A St. Louis	22c. DATE SIGNED 8/26/60
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 8/29/60	23c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis County, Mo.

24. FUNERAL DIRECTOR Charles J. Gates	ADDRESS 4107 Finney	25. DATE RECD. BY LOCAL REG. AUG 26 1960	26. REGISTRAR'S SIGNATURE Loan Smith M.D.
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DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

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 _____

Licensed Embalmer No. 1825

P. O. Address 4107 Finney A

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.