

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-017878
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 3000 Primary Registration District No. 3000 Registrar's No. 158

FILED MAY 21 1962

VS 300
Rev. 4/59

0017

2 0017

3

4 1

5 2

6

7 0

8 1

9 451X

10

11

12 1-0

13 1-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY Adair		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Adair	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kirkville		Length of stay in 1b yrs.	c. CITY OR TOWN Kirkville Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Grim-Smith Hosp.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 407 E Normal Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) FANNIE TUCKER		4. DATE OF DEATH Month May Day 17 Year 1962	
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6-17-1890
9. AGE (last birthday) 71		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY Domestic	11. BIRTHPLACE (City and state or country) Newtown, Missouri
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME Thomas Maxwell	
13b. MOTHER'S MAIDEN NAME Mina Bowers		14. NAME OF HUSBAND OR WIFE Harley Tucker (D)	
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 Mrs. Norton Bohon, Kirkville, Mo.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured Aneurysm, Abdominal Aorta Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerosis DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 48 hrs. 2 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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 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 5-15-62 to 5-17-62 and last saw her alive on 5-17-62 Death occurred at 8:15 A m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>J. J. Jones</i> (Doctor or title)		22b. ADDRESS Kirkville, Mo.	22c. DATE SIGNED 5-17-62
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 5-19-1962	23c. NAME OF CEMETERY OR CREMATORY Maple Hills Cemetery	23d. LOCATION (City, town, or county) (State) Kirkville, Missouri
24. FUNERAL DIRECTOR Davis & Davis, Kirkville, Mo.		25. DATE RECD. BY LOCAL REG. 5-18-1962	26. REGISTRAR'S SIGNATURE <i>Gene W. Ratliff</i>

Permit issued May 18, 1962

J. B. JONES, M.D.

MAY 25 1962

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 Robert B. Davis

Licensed Embalmer No. 4219

P. O. Address Kirkville, 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.