

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

0016217

Registration District No. 316 Primary Registration District No. 3059 Registrar's No. 160 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

DATE AMENDED

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>APPL 28864 MOIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>ST. FRANCIS</u>	
b. CITY (if outside corporate limits, give TOWNSHIP only) <u>BOHNE TERRACE</u>		Length of stay in lb <u>7 days</u>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>HOSPITAL</u>		d. STREET ADDRESS (If outside, give location) <u>FOURTH ST.</u>	
3. NAME OF DECEASED (Type or print) First <u>SOPHIA</u> Middle <u>JANE</u> Last <u>TUCKER.</u>		4. DATE OF DEATH Month <u>APR</u> Day <u>10</u> Year <u>1964</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>JULY 7, 1894</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE OFFICER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSE WIFE</u>	11. BIRTHPLACE (City and state or country) <u>MADISON MO.</u>
13a. FATHER'S NAME <u>JAMES MARTIN</u>		14. NAME OF HUSBAND OR WIFE <u>JAMES TUCKER.</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>		17. INFORMANT Address <u>MR. JAMES TUCKER Flat River, 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>Arteriosclerotic heart disease</u> Interval between ONSET AND DEATH <u>known 5 yrs</u>	
DUE TO (b)		<u>Diabetes mellitus</u> <u>known 5 yrs</u>	
DUE TO (c)		<u>+ Arterial hypertension</u> <u>known 5 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I <u>Bronchial Asthma, Chronic glomerular nephritis</u>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 a.m. p.m. Month, Day, Year			
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>1958</u> to <u>April 10, 1964</u> and last saw her alive on <u>April 10, 1964</u> Death occurred at <u>12 30 / P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>J. L. Foster</u> (Degree or title) <u>MD</u>		22b. ADDRESS <u>Desloge Mo</u>	
22c. DATE SIGNED <u>4-12-64</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>4/12/64</u>	23c. NAME OF CEMETERY OR CREMATORY <u>WOODLAWN IEM.</u>	23d. LOCATION (City, town, or county) (State) <u>Esther Missouri</u>
24. FUNERAL DIRECTOR <u>JALOWELL &amp; SONS</u> ADDRESS <u>FLAT RIVER, MO.</u>		25. DATE RECD. BY LOCAL REG. <u>April 25, 1964</u>	26. REGISTRAR'S SIGNATURE <u>Ether Rudloff</u>

USE BLACK INK OR TYPEWRITER RIBBON

Permit issued Apr. 12 - 1964

APR 29 1964

APR 29 1964

**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 Donald Dale Caldwell

Licensed Embalmer No. 5095

P. O. Address Flat River, 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: