No. 2
—5-42
5-17-39
I X32873

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT. 5 1942

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

29397

State File No.

Registration District No. 149 Primary Registration District No. 10.2 Registrar's No. 3479

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Research Hosp. O
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 days (Specify whether
In this community 5 days years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Chariton

(c) City or town Keytesville Mo.
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Alburn Chiles Drace

3. (b) If veteran, name war Mo

3. (c) Social Security No. Mo.

4. Sex Male

5. Color or Race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Irene Drace

6. (c) Age of husband or wife if alive 58 years

7. Birth date of deceased July 26 1882 (Month) (Day) (Year)

8. AGE: Years 60 Months 1 Days 26 If less than one day hr. min.

9. Birthplace Missouri O (City, town, or county) (State or foreign country)

10. Usual occupation Probate Judge

11. Industry or business Chariton Co Mo

FATHER
12. Name Wm J. Drace
13. Birthplace Mo. O (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Frankie Chiles
15. Birthplace Mo. O (City, town, or county) (State or foreign country)

16. (a) Informant Wm Alburn Drace
(b) Address Keytesville Mo

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Sept-22-42 (Month) (Day) (Year)
(c) Place: burial or cremation Keytesville Mo

18. (a) Signature of funeral director Wm C. L. Foster
(b) Address 918 Brooklyn

19. (a) 9/22/42 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 22 year 1942 hour 8 a.m. minute M.

21. I hereby certify that I attended the deceased from Sept 18 1942 to Sept 22 1942 that I last saw h. 1 m. alive on 8 a.m. Sept 22 42 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Myocardial Exhaustion Acute	
Due to Intestinal Obstructions 1370	
Due to Post operative prostatic hemorrhage	
Other conditions Prostatic Hypertrophy Benign (Include pregnancy within 3 months of death)	

Major findings:
Of operations All 3 lobes enlarged
Of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature [signature] (M. D. or other) MD
Address 1019 Prof Bldg KCMo Date signed 9/22/42

(Licensed Embalmer's Statement on Reverse Side)

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed. Dwight C. Browning

Licensed Embalmer No. 2724

P. O. Address. 95 C. 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 this body is not embalmed, fact should be so stated above.