

V. S. No. 2
M-11-10-39
5-17-39
X21492

13984

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

ED APR 23 1943

Registration District No. 29

Primary Registration District No. 5224

No. 74

1000
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County Leas
(b) City or town Harrisonville (Rural)
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Grand River Hosp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 61 yrs.
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Leas
(c) City or town Harrisonville (Rural)
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A. 0 years

3. (a) PRINT FULL NAME Fred R. Tramill
8. (b) If veteran, name war _____ 8. (c) Social Security No. _____
4. Sex male 5. Color or race white
6. (a) Single, widowed, married, divorced single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife If
alive _____ years

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month April day 7th
year 1943 hour 9 minute 30 P. M.
21. I hereby certify that I attended the deceased from Mar 28
1942 to April 7 1943
that I last saw him alive on April 7, 1943
and that death occurred on the date and hour stated above.

7. Birth date of deceased Dec. 6 1881
(Month) (Day) (Year)
8. AGE: Years Months Days If less than one day
61 4 1 hr. _____ min.

Immediate cause of death Myocardial
regeneration of heart
aged peripheral atherosclerosis
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) 92 B

9. Birthplace Mo. O
(City, town, or county) (State or foreign country)
10. Usual occupation Farmer
11. Industry or business _____
12. Name Robert Tramill
13. Birthplace Ill.
(City, town, or county) (State or foreign country)
14. Maiden name Delia Walker
15. Birthplace Mo. O
(City, town, or county) (State or foreign country)

Major findings:
Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant Charles F. ...
(b) Address Washington City Mo
17. (a) Burial (b) Date thereof April 9, 1943
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Pleasant Ridge Cem.
18. (a) Signature of funeral director [Signature]
(b) Address Washington City Mo
19. (a) April 12, 1943 (b) Margaret ...
(Date received local registrar) (Registrar's signature)

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?
While at work? _____ (Specify type of place)
(e) Means of injury _____
23. Signature E. M. Guffey (M. D. or other)
Address Harrisonville, Mo. Date signed 3/9/42

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.....

J. W. Kaufman....., Registered Apprentice No.
working under my personal supervision.

Signed *J. W. Kaufman*.....

Licensed Embalmer No. *1030*.....

P. O. Address *Lawrence City 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, above space should be left blank.