Y. S. No. 2
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ev. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

23494

State File No. 6339

FILED JUL 26 1944

Registration District No. ____ Primary Registration District No. 1003 Registrar's No. ____

1. PLACE OF DEATH:

(a) County ____

(b) City or town St. Louis Mo
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Barnard's Skin & Cancer Hospital
(If not in hospital or institution, write street number or location)

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

2. USUAL RESIDENCE OF DECEASED: 999

(a) State Illinois (b) County Crawford

(c) City or town Oblong 11 NR.
(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 2

3. (a) PRINT FULL NAME JOHN W. TRACY

3. (b) If veteran, name war none

3. (c) Social Security No. none

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Rachel E. Tracy

6. (c) Age of husband or wife if alive 67 years

7. Birth date of deceased Oct. 25th 1867 (Month) (Day) (Year)

8. AGE: Years 76 Months 8 Days 20 If less than one day ____ hr. ____ min.

9. Birthplace Richland County Illinois (City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business ____

MOTHER FATHER

12. Name Phillip Tracy

13. Birthplace unknown unknown (City, town, or county) (State or foreign country)

14. Maiden name Mildred Tull

15. Birthplace Little Rock Arkansas (City, town, or county) (State or foreign country)

16. (a) Informant Lee Tracy

(b) Address Oblong Illinois

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 7-15-44 (Month) (Day) (Year)

(c) Place: burial or cremation Oblong Illinois

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Ave

19. (a) JUL 18 1944 (Date received local registrar) (b) J. F. Buesche (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 15 year 1944 hour 9:50 a.m. minute ____ a.m.

21. I hereby certify that I attended the deceased from 7-8 1944 to 7-15 1944 that I last saw him alive on July 10 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Hydrocephalus / pneumonia — Duration 1 D.

Due to post-op complication following radical cancer

Due to recurrence of recurrence orbital operation cancer

Other conditions Primary site.
(Include pregnancy within 3 months of death)

Major findings:
Of operations Extension of tumor through frontal sinus to brain.
Of autopsy ____

PHYSICIAN Check 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 Helen E. Reller (M. D. or other) M. D.

Address 4514 Clarence Date signed 7/15/44

(Licensed Embalmer's Statement on Reverse Side)

6339

6339

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 John Agonoski

Licensed Embalmer No. 3398

P. O. Address.....

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.