

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **26743**

FILED AUG 30 1949

BIRTH NO. _____ REG. DIST. NO. **137** PRIMARY REG. DIST. NO. **3023** Registrar's No. **194**

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| 1. PLACE OF DEATH a. COUNTY Henrylaire | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Morgan | |
| b. CITY (If outside corporate limits, write RURAL and give town) Clinton | | c. CITY (If outside corporate limits, write RURAL and give township) Warrailes | |
| c. LENGTH OF STAY (In this place) 5 Days | | d. STREET ADDRESS (If rural, give location) Wetzel | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION | | | |

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|---|----------------------------------|--|--|--|--|--|--|
| 3. NAME OF DECEASED a. (First) James | | b. (Middle) Timothy | | c. (Last) Tracy | | 4. DATE OF DEATH (Month) (Day) (Year) Aug: 20: 49 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married | | 8. DATE OF BIRTH Jan: 13, 1882 | | 9. AGE (In years last birthday) 67 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Missouri | | 12. CITIZEN OF WHAT COUNTRY? US. | |

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|--|--|---|--|--|--|
| 13a. FATHER'S NAME Aleck Tracy | | 13b. MOTHER'S MAIDEN NAME Cyntha Sidebottom | | 14. NAME OF HUSBAND OR WIFE Sarah J. Tracy | |
|--|--|---|--|--|--|

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|--|--|---|--|---|--|---------|--|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 703-03-0470 | | 17. INFORMANT'S SIGNATURE OR NAME Sarah J. Tracy Mnegaw Spgs: M | | ADDRESS | |
|--|--|---|--|---|--|---------|--|

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|---|--|--|--|--|--|----------------------------------|--|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | | MEDICAL CERTIFICATION | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis | | ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | | | 4201 | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | | | | | |

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|------------------------|--|----------------------------------|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
|------------------------|--|----------------------------------|--|--|--|---|--|

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|--|--|--|--|---|--|
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | |

22. I hereby certify that I attended the deceased from **8/14/49, 19** to **8/20/49, 19**, that I last saw the deceased alive on **8/20/49, 19**, and that death occurred at **10:30 a. m.**, from the causes and on the date stated above.

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|--|--|---|--|---|--|
| 23a. SIGNATURE (Degree or title) Miss M. Tracy | | 23b. ADDRESS Benton Missouri | | 23c. DATE SIGNED 8/20/49 | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24b. DATE 8/22/49 | | 24c. NAME OF CEMETERY OR CREMATORY Benton Green | |
| | | 24d. LOCATION (City, town, or county) (State) Robcoe Missouri | | | |

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|--|--|--|--|---|--|------------------------------|--|
| DATE REC'D BY LOCAL REG. Aug 22 1949 | | REGISTRAR'S SIGNATURE Florence Adair | | 25. FUNERAL DIRECTOR'S SIGNATURE J. B. Goodrich | | ADDRESS Osceola Mo | |
|--|--|--|--|---|--|------------------------------|--|

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

District Health Officer No. 71

District File Number 7-49-1018

Date Filed 8-29-49

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.

6
Student
Student Embalmer

Signed F. B. G. Smith

Licensed Embalmer No. 3038

P. O. Address Orlando, Fla

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.