

MAR 29 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **10681**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **2268**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
c. LENGTH OF STAY (In this place) 66yrs		2109	
d. FULL NAME OF HOSPITAL OR INSTITUTION: 4130W Natural Bridge		d. STREET ADDRESS (If rural, give location) 10 4130W Natural Bridge	
3. NAME OF DECEASED a. (First) Catherine b. (Middle) Elizabeth c. (Last) Tracy			4. DATE OF DEATH March 9 1952
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Jan. 11 1886
9. AGE (In years last birthday) 66		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (State or foreign country) Missouri
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY? U.S.
13a. FATHER'S NAME John Duffy		13b. MOTHER'S MAIDEN NAME Margaret Kinney	14. NAME OF HUSBAND OR WIFE John
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME John Tracy ADDRESS 4130W Natural Bridge

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Crohn's Disease		DUE TO (b) Carcinoma of Gut + Liver		3 yrs.
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		DUE TO (c)		1 yr.
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		Ascites Abdominal		6 months

19a. DATE OF OPERATION 11/5/1952	19b. MAJOR FINDINGS OF OPERATION Paracentesis Abdominal	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 1.56!

22. I hereby certify that I attended the deceased from **7/20/1946**, to **March 9, 1952**, that I last saw the deceased alive on **March 9, 1952**, and that death occurred at **6:50 P. M.**, from the causes and on the date stated above.

23a. SIGNATURE Ann Krall (Degree or title) M.D.	23b. ADDRESS 2416 ex Grand	23c. DATE SIGNED 3/10/52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 3/12/1952	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis Missouri
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DATE REC'D BY LOCAL REG. MAR 10 1952	REGISTRAR'S SIGNATURE J. Carl Smith	FUNERAL DIRECTOR'S SIGNATURE Wm. J. Marcell ADDRESS 4214 St. Louis Ave
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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
Student Embalmer

Signed

John S. Deane

Licensed Embalmer No. _____

4194

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.