

S. No. 300
IV. 10.48

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

FILED JAN 14 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 44689
Registrar's No. 3305

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 547

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Richmond Hts.	c. LENGTH OF STAY (in this place) 1 Week	c. CITY OR TOWN St. Louis	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Mary's Hospital		e. STREET ADDRESS (If rural, give location) 5626 Bancroft Ave. 2149	

3. NAME OF DECEASED (Type or Print) a. (First) JOHN b. (Middle) J. c. (Last) TRACY	4. DATE OF DEATH (Month) (Day) (Year) Dec. 29 1953
--	--

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Aug. 5, 1900	9. AGE (In years last birthday) 53	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
--------------------	-------------------------------	---	--------------------------------------	---	---	---

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sanitarian-Bd. Of Health-City of	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
---	---	--	--

13a. FATHER'S NAME John A. Tracy	13b. MOTHER'S MAIDEN NAME Emma Franz	14. NAME OF HUSBAND OR WIFE Hope M. Tracy
---	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None	16. SOCIAL SECURITY NO. 496-18-2977	17. INFORMANT'S SIGNATURE OR NAME Hope M. Tracy ADDRESS 5626 Bancroft Ave.
--	--	--

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.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiovascular accident		INTERVAL BETWEEN DEATH AND DEATH 7 days
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) haemorrhic cerebrosis		
	DUE TO (c) _____		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

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

21a. ACCIDENT SUICIDE HOMICIDE (Specify) None	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) _____ m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? None
--	--	--

22. I hereby certify that I attended the deceased from **Dec. 23, 1953**, to **Dec. 29, 1953**, that I last saw the deceased alive on **12:30 PM, 1953**, and that death occurred at **5:45 PM**, from the causes and on the date stated above.

23a. SIGNATURE Howard Maller M.D. (Degree or title)	23b. ADDRESS 819 W. Main Club Bldg.	23c. DATE SIGNED Dec 30, 1953
--	--	--------------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Jan. 2, 1954	24c. NAME OF CEMETERY OR CREMATORY Lakewood Park Cem.	24d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.
---	-------------------------------	--	--

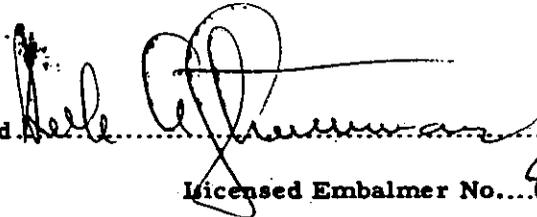
DATE REC'D BY LOCAL REG. 12/30/53	REGISTRAR'S SIGNATURE Herbert G. ...	25. FUNERAL DIRECTOR'S SIGNATURE Kriegshauser ADDRESS 4228 S. Kingshighway Bl.
--	---	--

(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, Student Embalmer No..... working under my personal supervision:.

Student.....
Signature of Student Embalmer

Signed .....
Licensed Embalmer No. 453

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.