THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-001922

STATE FILE NUMBER

FILED FEB 3 1959 Registration District No. 172 Primary Registration District No. 3034 Registrar's No. 9

1. PLACE OF DEATH
a. COUNTY LAFAYETTE
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN HIGGINSVILLE — Inside Limits Yes ☒ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) SCHLEICHER HOME — Length of stay in 1b 49 DAYS

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MISSOURI b. COUNTY LAFAYETTE
c. CITY OR TOWN MAYVIEW 0540 — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First CHARLES Middle — Last TRACY

4. DATE OF DEATH Month JAN Day 23 Year 1959

5. SEX MALE
6. COLOR OR RACE WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ 2 DIVORCED ☐
8. DATE OF BIRTH MAR 21 1880
9. AGE (In years last birthday) 78 — IF UNDER 1 YEAR Months 10 Days 3 — IF UNDER 24 HRS. Hours Min. 36

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LIVESTOCK DEALER
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (City and state or country) MAYVIEW MISSOURI
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME CHARLES TRACY
13b. MOTHER'S MAIDEN NAME ELIZABETH KINCHELOE
14. NAME OF HUSBAND OR WIFE —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. —
17. INFORMANT DEE W. TRACY Address LEE'S SUMMIT MO.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Uremia — INTERVAL BETWEEN ONSET AND DEATH 1 week
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Urinary Retention — 1 month
DUE TO (c) Chronic Prostatitis — Yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) ACV Disease 611X
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ 2

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 12/4/58, to 1/23/59 and last saw him alive on 1/22/59
Death occurred at 12:15 A. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Robert B. Best, M. D. C
22b. ADDRESS Higginsville, Mo.
22c. DATE SIGNED 1/26/59

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
23b. DATE JAN 25 1959
23c. NAME OF CEMETERY OR CREMATORY MT. TABOR CEMETERY
23d. LOCATION (City, town, or county) LAFAYETTE CO. (State) MISSOURI

24. FUNERAL DIRECTOR AHHADER FUNERAL HOME BY G. J. Hader ADDRESS HIGGINSVILLE, MISSOURI
25. DATE RECD. BY LOCAL REG. Jan 28. 1959
26. REGISTRAR'S SIGNATURE Lutie Gordon Jordan

(Licensed Embalmer's Statement on Reverse Side)

Mid = Robert B. Best

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FEB 11 1959

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 Wm. L. Thurman

Licensed Embalmer No. 4563

P. O. Address Richmond, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.