

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS APR 4 1960

60-013311

STATE FILE NUMBER

2 2877

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Saint Louis		c. CITY OR TOWN University City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Lukes Hospital		d. STREET ADDRESS (If outside, give location) 6640 Waterman Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First NELSON Middle N. Last TRACY	4. DATE OF DEATH Month March Day 10 Year 1960
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5. SEX male	6. COLOR OR RACE white	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7/18/1886	9. AGE (last birthday) 73	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired	10b. KIND OF BUSINESS OR INDUSTRY grocery	11. BIRTHPLACE (City and state or country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME John Tracy	13b. MOTHER'S MAIDEN NAME Margaret N. Cholson	14. NAME OF HUSBAND OR WIFE Florence M. 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) no	16. SOCIAL SECURITY NO. none	17. INFORMANT Florence Tracy Address 6640 Waterman
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 2 hours
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Acute Myelocytic Leukemia	1 month
	DUE TO (c) 204.2	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N- <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
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21. I attended the deceased from **3 April 1958** to **10 March '60** and last saw ^{him} live on **10 March '60**
Death occurred at **10:30 pm** on **10 March '60** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>Herb S. Shively M.D.</i> (Degree or title)	22b. ADDRESS 3540 Central, Clayton 5 Mo	22c. DATE SIGNED 3-11-60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 3/12/60	23c. NAME OF CEMETERY OR CREMATORY Bellefontaine Cemetery St. Louis	23d. LOCATION (City, town, or county) Missouri
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24. FUNERAL DIRECTOR C. R. Lupton and sons 7233 Delmar ADDRESS	25. DATE RECD. BY LOCAL REG. MAR 11 1960	26. REGISTRAR'S SIGNATURE <i>Herb S. Shively M.D.</i>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Arnold W. Schoene

Licensed Embalmer No. 3864
P. O. Address St. Louis

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.