

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

5275

FEB 25 1929

1. PLACE OF DEATH
 County Worth Registration District No. 903
 Township West Branch Primary Registration District No. 4545
 City Grant City (No. _____) _____ St. _____ Ward _____

2. FULL NAME Rebecca Traker
 (a) Residence No. _____ St. _____ Ward _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred 70 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Samuel W. Traker

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 1 1834

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
94 | 3 | 1

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work at home
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Waffarsa, Ind
 (STATE OR COUNTRY) Indiana

10. NAME OF FATHER Isaac Miller

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unknown
 (STATE OR COUNTRY) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown
 (STATE OR COUNTRY) Unknown

14. INFORMANT H. W. Traker
 (Address) 2105 Dewey Ave. at West 12th

15. FILED 1-3-29 John Cepner REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 2 1929

17. I HEREBY CERTIFY, That I attended deceased from Dec 25, 1928 to Jan 2, 1929 that I last saw h. alive on Jan 5, 1929, and that death occurred, on the date stated above at _____ m.
 THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pneumonia
11A
110V 197A
110V 1107A
 CONTRIBUTORY (SECONDARY) Senility - Influenza
 (duration) yrs. mos. da. (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED _____
 IF NOT AT PLACE OF DEATH? _____

19. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
 WAS THERE AN AUTOPEX? _____
 WHAT TEST CONFIRMED DIAGNOSIS? _____
 (Signed) John Cepner, M.D.
 (Address) Grant City Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENCE CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL City Cemetery DATE OF BURIAL 1/4/1929

20. UNDERTAKER Arch C. Dunfee ADDRESS Grant City Mo.

WRITE PLAINLY WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

113
2
2
235
2
31
31

