

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

Do not use this space.

5562

1. PLACE OF DEATH

County Jackson Registration District No. _____
Township Haw Primary Registration District No. _____
City Kansas City (No. 3425 Harrison) St. _____ Ward _____

File No. _____
Registered No. 602
St. _____ Ward _____

2. FULL NAME

Miss Keith Tracy
(a) Residence. No. 3425 Harrison St. 6 Ward.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) single

5. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 8 - 1896

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
35 1 1

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. formally 2nd stringer
(b) General nature of industry, business, or establishment in which employed (or employer). Southwest News Co.
(c) Name of employer 12 yrs there

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kansas City Mo.

10. NAME OF FATHER Phos. Edw. Tracy

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

12. MAIDEN NAME OF MOTHER Bessie L. Green

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

14. INFORMANT James S. Jackson
(Address) 5155 Wornall Rd.

15. FILED 7/10/31 1931 M. M. Grove
REGISTRAR Asst

MEDICAL CERTIFICATE OF DEATH Monday

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-9 1931

17. I HEREBY CERTIFY (That I attended deceased from _____, 19____, to _____, 19____, and that I last saw him alive on _____, 19____, and that death occurred, on the date stated above, at _____, 19____, m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Suicide: Poisoning acid, a grain
1630 (duration) _____ yrs. mos. da.

CONTRIBUTORY (SECONDARY) 163 (duration) _____ yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS Autopsy

(Signed) Charles M. Haeel, M. D.

79 . 19 31 (Address) Deputy Coroner

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL mt Washington DATE OF BURIAL 2-11 1931

20. UNDERTAKER Eyles Funeral Home ADDRESS 1800 Lincolnwood

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.

