

REC'D MAR 24 1938

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

6770
Do not use this space.

1. PLACE OF DEATH *Greene* ?
 (a) County *Greene* Registration District No. *315*
 (b) Township *Springfield* Primary Registration District No. *2001*
 (c) City *Springfield* (d) Street No. *2015 E. Kearney* Registered No. *129*
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.
 2. PRINT FULL NAME *ISAAC T. TRACY* 620
 (a) Residence, No. *2015 E. Kearney* St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *male*
 4. COLOR OR RACE *white*
 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *married*
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Lucretia Tracy*
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *April 15-1858*
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
 ✓ *79* *9* *24*
 OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *Retired farmer*
 9. Industry or business in which work was done, as saw mill, bank, etc. *on farm*
 10. Date deceased last worked at this occupation (month and year) ✓
 11. Total time (years) spent in this occupation ✓

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *2/8/38* 19*38*
 22. I HEREBY CERTIFY, That I attended deceased from *2-1-1938* to *2-9-1938*, 19*38*
 I last saw him alive on *2-8-1938*, 19*38*. Death is said to have occurred on the date stated above, at *104* m.
 The principal cause of death and related causes of importance were as follows:
Lobar pneumonia
 Date of onset *2-3-38*
 Other contributory causes of importance:
seriously
 Name of operation Date of
 What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? Date of injury 19.....
 Where did injury occur? (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.
 Manner of injury
 Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
 If so, specify
 (Signed) *O. E. Feller* M. D.
 (Address) *Springfield Mo*

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Mo.*
 FATHER
 13. NAME *Evan Tracy*
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Ky.*
 MOTHER
 15. MAIDEN NAME *Arish Kershaw*
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Ky.*
 17. INFORMANT (ADDRESS) *C. M. Tracy Springfield, Mo.*
 18. BURIAL (CREMATION, OR REBURY) PLACE *Cedar Hill* DATE *Feb 10 1938*
 19. FUNERAL DIRECTOR (ADDRESS) *W. H. Hughes & Co. Springfield, Mo.*
 20. FILED *Feb 10 1938* *Chas A. Brown* Local Registrar.

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.

1 X12004

STATEMENT BY LICENSED EMBALMER

I, J. B. Klingner, Licensed Embalmer No. 3358

hereby certify that the body recorded on the reverse side of this certificate was embalmed by

L. E. Roy A. Cavin

No. 1763 or by _____, Registered Apprentice No. _____

working under my personal supervision.

Signed J. B. Klingner
Licensed Embalmer No. 3358

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.)