

# MISSOURI STATE BOARD OF HEALTH

## BUREAU OF VITAL STATISTICS

### CERTIFICATE OF DEATH

# 17534

Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399

(b) Township Kaw Primary Registration District No. 1002

(c) City Kansas City (d) Street No. 1123 Troost St. \_\_\_\_\_

(If death occurred in Hospital or Institution, write its name instead of street and number)

(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 Julius A. Tralle 640

(a) Residence, No. 1123 Troost 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 <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Widowed</u>	
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Anna Tralle</u>			
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Jan. 14 1855</u>			
7. AGE YEARS <u>83</u>	MONTHS <u>4</u>	DAYS <u>16</u>	If LESS than 1 day, ..... hrs. or ..... min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>Retired</u>		
	9. Industry or business in which work was done, as saw mill, bank, etc. <u>Saloon-keeper</u>		
	10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____		
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Washington Mo.</u>			
FATHER	13. NAME <u>Henry Tralle</u>		
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>No Record</u>		
MOTHER	15. MAIDEN NAME <u>No Record</u>		
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>No Record</u>		
17. INFORMANT (ADDRESS) <u>Mrs. Lotte Martin 1123 Troost</u>			
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>St. Marys</u> DATE <u>June 1 1938</u>			
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>Quirk &amp; Tobin Co. Kansas City, Mo.</u>			
20. FILED <u>May 31, 1938 M. M. Brown</u> Local Registrar.			

#### MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 30 1938

22. I HEREBY CERTIFY, That I attended deceased from May 21 1938 to May 30 1938

I last saw him alive on May 30 1938 Death is said to have occurred on the date stated above, at 4:20 P.

The principal cause of death and related causes of importance were as follows:

Uremia  
Chronic Glomerular  
Nephritis

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Other contributory causes of importance:

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? Urea test Was there an autopsy? no

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? no

If so, specify \_\_\_\_\_

(Signed) George C. Kelly M. D.

(Address) 730 Professional Bldg

A. C. Mo. J.

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.

**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 .....

Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**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 this body is not embalmed, above space should be left blank.**