

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **43856**

Registration District No. **317**

Primary Registration District No. **6076**

Registrar's No. **2781**

1. PLACE OF DEATH:

(a) County **St. Louis**

(b) City or town **Grand Tower**  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution  
**4116 Cedarwood /**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **St. Louis**

(c) City or town **Grand Tower**  
(If outside city or town limits, write "RURAL")

(d) Street No. **4116 Cedarwood**  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **JOSEPH TRACY.**

3. (b) If veteran, name war **None**

3. (c) Social Security No. **None**

4. Sex **Male** 5. Color or race **White**

6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife **Marcella Tracy**

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased **July 9, 1870.**  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **12** day **11**  
year **43** hour **9** minute **30** A.M.

21. I hereby certify that I attended the deceased from **9-2-43**, 19\_\_\_\_, to **12-11-43**, 19\_\_\_\_;  
that I last saw h. **alive** on **12-10-43**, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

8. AGE: Years **73** Months **5** Days **2** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace **Ireland** \_\_\_\_\_  
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired**

11. Industry or business **Saloon**

12. Name **Michael Tracy**

13. Birthplace **Ireland** \_\_\_\_\_  
(City, town, or county) (State or foreign country)

14. Maiden name **Hopman**

15. Birthplace **Ireland** \_\_\_\_\_  
(City, town, or county) (State or foreign country)

Immediate cause of death **Cerebral Hemorrhage** Duration **3 mo**

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **8301**

Of autopsy \_\_\_\_\_

PHYSICIAN  
Underline the cause to which death should be charged statistically.

16. (a) Informant **Michael Tracy**

(b) Address **4116 Cedarwood**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **Dec 14 1943**  
(Month) (Day) (Year)

(c) Place: burial or cremation **Mount Olive Cemetery**

18. (a) Signature of funeral director **J. J. Quinn**

(b) Address **1359 Highland Ave**

19. (a) **DEC 16 1943** (Date received local registrar)

(b) **E. H. Bowman** (Registrar's signature)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? (Specify type of place) (e) Means of injury \_\_\_\_\_

25. Signature **E. H. Bowman** (M. D. or other) \_\_\_\_\_

Address **634 M. Grand** Date signed **12-13-43**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

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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 *Harry J. Schumacher*

Licensed Embalmer No. *2679*

P. O. Address *732 Fenway Ave.*

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, fact should be so stated above.