

S. No. 2
DM-8-43
v. 5-17-39
X37823

27758

DEPARTMENT OF COMMERCE THE STATE BOARD OF HEALTH OF MISSOURI
FILED SEP 7 1945 STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 171

Primary Registration District No. 4267

Registrar's No. 41

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

1. PLACE OF DEATH: Lafayette
 (a) County Lafayette
 (b) City or town Odessa
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: _____
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether)
 In this community Life years, months or days

3. (a) PRINT FULL NAME Kemp Tracy
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M (1) 5. Color or race W
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Gertrude Tracy 6. (c) Age of husband or wife if alive 70 years
 7. Birth date of deceased November 18 1870
 (Month) (Day) (Year)

8. AGE: Years 74 Months 8 Days 28 If less than one day hr. _____ min. _____

9. Birthplace Lafayette Co. Mo.
 (City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER } 12. Name Asa C. Tracy

13. Birthplace Kentucky
 (City, town, or county) (State or foreign country)

14. Maiden name Molly Gibbs

15. Birthplace Missouri
 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Kemp Tracy

(b) Address Odessa, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 17, 1945
 (Month) (Day) (Year)

(c) Place: burial or cremation Odessa Mo. Cem. Husman-Sparks

18. (a) Signature of funeral director Odessa Mo.
 (b) Address _____

19. (a) Aug-30-1945 (Date received local registrar) (b) Travis W. Baker (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Lafayette 521
 (c) City or town Odessa 4
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location) 0
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 16 year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from Aug 14, 1945, to Aug 16, 1945, and that death occurred on the date and hour stated above.

Immediate cause of death Encephalitis Hemorrhagica (Hemiplegia) secondary to Hypertension
Respiratory

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

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) Manner of injury _____

23. Signature [Signature] (M. D. or other) _____

Address Odessa Mo Date signed 8/16/45

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

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed _____

9-6-45

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 _____

W. J. Sparks

Registered Apprentice No. *385*

working under my personal supervision.

Signed _____

Irving T. Husman

Licensed Embalmer No. *7541*

P. O. Address _____

Odessa, Mo

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.