

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

24473

State File No.

FILED AUG 7 - 1953

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 702

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Greene	
b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN Springfield		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Fair Grove	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) Fair Grove	
d. FULL NAME OF HOSPITAL OR INSTITUTION City Hospital			

3. NAME OF DECEASED (Type or Print) KITT			4. DATE OF DEATH (Month) (Day) (Year) July 31 1953		
a. (First)	b. (Middle)		c. (Last)		
			TRACY		

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 22 January 1888	9. AGE (In years last birthday) 65	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 YEAR Hours	IF UNDER 1 YEAR Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY In Home	11. BIRTHPLACE (State or foreign country) Missouri	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME David Shelby	13b. MOTHER'S MAIDEN NAME Martha Shelby	14. NAME OF HUSBAND OR WIFE Harrison Tracy
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. UNKNOWN	17. INFORMANT'S SIGNATURE OR NAME Harrison Tracy	ADDRESS Fair Grove, Mo.
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pulmonary Edema</u>		DUE TO (b) <u>Cerebral Vascular Accident</u>		<u>2 weeks</u>
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		DUE TO (c) <u>Hypertensive Cerebrovascular D.</u>		<u>10 days</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 443X	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from JULY 16, 1953, to JULY 31, 1953, that I last saw the deceased alive on July 31, 1953, and that death occurred at 3:10P m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Carl D. Kessel MD</u>	23b. ADDRESS <u>1951 So. National</u>	23c. DATE SIGNED <u>8-4-53</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 2 August 1953	24c. NAME OF CEMETERY OR CREMATORY Cedar Bluff Ceme.	24d. LOCATION (City, town, or county) (State) Greene County Mo.
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DATE REC'D BY LOCAL REG. 8-5-53	REGISTRAR'S SIGNATURE <u>Earl Williams</u>	25. FUNERAL DIRECTOR'S SIGNATURE J.W. KLINGNER & CO.	ADDRESS Springfield, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

0.300
0.48

0

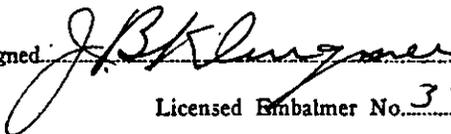
STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed: 

Licensed Embalmer No. 3358

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, fact should be so stated above.