

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

4094

State File No. _____

BIRTH NO. FILED FEB 23 1954 REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 190

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| 1. PLACE OF DEATH a. COUNTY <u>Buchanan</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institutional, residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u> | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u> | | c. CITY OR TOWN <u>St. Joseph</u> | |
| c. LENGTH OF STAY (In this place) <u>45 Yrs</u> | | d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Mo. Methodist Hospital</u> | | e. STREET ADDRESS (If rural, give location) <u>233 Ill. Ave.</u> | |

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| 3. NAME OF DECEASED (Type or Print) a. (First) <u>Merrill</u> | b. (Middle) <u>James</u> | c. (Last) <u>Tracy</u> | 4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 17, 1954</u> |
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| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Divorced</u> | 8. DATE OF BIRTH <u>Jan. 27, 1908</u> | 9. AGE (In years last birthday) <u>46</u> | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 24 HRS. Hours _____ Min. _____ |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Car Line Foreman</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>Armour's</u> | 11. BIRTHPLACE (City and State or Foreign Country) <u>Kansas City, Kans.</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
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| 13a. FATHER'S NAME <u>James Tracy</u> | 13b. MOTHER'S MAIDEN NAME <u>Nellie Egan</u> | 14. NAME OF HUSBAND OR WIFE <u>Margaret Tracy</u> |
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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) <u>No</u> | 16. SOCIAL SECURITY NO. <u>487-09-1934</u> | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs Nellie Tracy 1824 Clay City</u> |
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| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic Pulmonary Emphysema</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Pulmonary Moniliasis (Cultured 11-20-53)</u> DUE TO (c) <u>Congestive Failure Secondary to a.</u> | INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u> |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | |

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| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION <u>5271</u> | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) <u>St. Joseph Mo</u> |
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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 11-8, 1953, to 2-17, 1954, that I last saw the deceased alive on 2-17, 1954, and that death occurred at 7:40p m., from the causes and on the date stated above.

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| 23a. SIGNATURE (Degree or title) <u>Irwin K. Gorenthal M.D.</u> | 23b. ADDRESS <u>St Joseph Mo</u> | 23c. DATE SIGNED <u>2/18-54</u> |
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| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 24b. DATE <u>Feb. 20, 1954</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u> | 24d. LOCATION (City, town, or county) (State) <u>St. Joseph, Mo.</u> |
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| DATE REC'D BY LOCAL REG. <u>Feb 20, 1954</u> | REGISTRAR'S SIGNATURE <u>Reathen M. Allison</u> | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Herman W. Sidinfaden, 1802 Union St. St. Joseph, Mo</u> |
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

No. 300
10-48

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.....
Signature of Student Embalmer

Signed..... *Robert H. Gage*
Licensed Embalmer No. 3308.....

P. O. Address St. Joseph, I.

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.