

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **4114**

FILED MAR 15 1954

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **5126** Registrar's No. **266**

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Iowa</b> b. COUNTY <b>Page</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Rural, Crawford Twp. transient</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Coin - Rural</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Near Faucett, Mo Highway 71 4 miles south</b>		d. STREET ADDRESS (If rural, give location) <b>Route 2</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>Delbert Carl</b> b. (Middle) <b>Tritsch</b> c. (Last) <b>Tritsch</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>March 8, 1954</b>		
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Feb. 18, 1930</b>	9. AGE (In years last birthday) <b>24</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Trucker</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Live Stock</b>	11. BIRTHPLACE (State or foreign country) <b>Fremont County Iowa</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Carl Tritsch</b>	13b. MOTHER'S MAIDEN NAME <b>Mary Gray</b>	14. NAME OF HUSBAND OR WIFE <b>Yvonne Tritsch</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>480-32-9283</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Carl Tritsch, Coin Iowa.</b>	ADDRESS _____
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Acute Strangulation and Suffocation</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Trauma of chest and neck</b>		
DUE TO (c) <b>Man was squeezed between the steering wheel and seatback of a tractor trailer when it left the road and went into a ditch, squeezing the man to death.</b>		32	
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 _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>Accident U.S. Highway #51</b>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Crawford Buchanan Mo</b>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>011 (STATE)</b>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>Mar 8-1954 9:10 P.M.</b>	21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>Tractor Trailer into a ditch</b>
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22. I hereby certify that I attended the deceased from **on 9/8, 1954**, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at **9:10 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>H F Mundy M.D. (Coroner)</b>	23b. ADDRESS <b>St Joseph Mo</b>	23c. DATE SIGNED <b>3/9/54</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>Mar. 9, 1954</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Locust Grove Cem.</b>	24d. LOCATION (City, town, or county) (State) <b>Northboro Iowa.</b>
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DATE REC'D BY LOCAL REG. <b>Mar 11, 1954</b>	REGISTRAR'S SIGNATURE <b>Kathleen M. Allison</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Clark</b>	ADDRESS <b>120 Illinois Av St. Joseph, Mo.</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

0.300  
0.48

0110  
3

8140  
8

MAR 29 1954

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 *Earl A Clark*

Licensed Embalmer No. *4238*

P. O. Address *St Joseph Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.