

FILED JUL 11 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

19108

State File No.

BIRTH NO. _____ REG. DIST. NO. 150 PRIMARY REG. DIST. NO. 5572 Registrar's No. 118

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural Prarie		c. CITY OR TOWN 509 N Main	
d. FULL NAME OF HOSPITAL OR INSTITUTION Jackson Co Hospital		e. STREET ADDRESS (If rural, give location) Independence	

3. NAME OF DECEASED (Type or Print) a. (First) Smith b. (Middle) T c. (Last) Tracy			4. DATE OF DEATH (Month) (Day) (Year) June 24 1955		
--	--	--	--	--	--

5. SEX M	6. COLOR OR RACE Wh	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH Jan 15 1871	9. AGE (In years last birthday) Months Days 84	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
--------------------	-------------------------------	--	--	--	--------------------------------	--------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carpenter		10b. KIND OF BUSINESS OR INDUSTRY O A P		11. BIRTHPLACE (City and State or Foreign Country) Kentucky		12. CITIZEN OF WHAT COUNTRY? usa	
---	--	---	--	---	--	--	--

13a. FATHER'S NAME Smith Tracy		13b. MOTHER'S MAIDEN NAME Elizabeth Compton		14. NAME OF HUSBAND OR WIFE Deceased	
--	--	---	--	--	--

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. None		17. INFORMANT'S SIGNATURE OR NAME James Tracy		ADDRESS Buckner Mo	
--	--	--	--	---	--	------------------------------	--

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) Cerebral Thrombosis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) 332x DUE TO (c) Arteriosclerosis II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Palpmitia				INTERVAL BETWEEN ONSET AND DEATH	
---	--	--	--	--	--	----------------------------------	--

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
------------------------	--	----------------------------------	--	--	--	---	--

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)	
--	--	--	--	---	--

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
---	--	--	--	----------------------------	--

22. I hereby certify that I attended the deceased from 5-5, 1951 to 6-24, 1955, that I last saw the deceased alive on 6-23, 1955, and that death occurred at 10 PM, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) David Woxman M.D.		23b. ADDRESS Jackson Co Hosp.		23c. DATE SIGNED 6-23-55	
--	--	---	--	------------------------------------	--

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 6-26-55		24c. NAME OF CEMETERY OR CREMATORY Oakland Cem		24d. LOCATION (City, town, or county) (State) By Independence MO	
--	--	-----------------------------	--	--	--	--	--

DATE REC'D BY LOCAL REG. 6-26-55		REGISTRAR'S SIGNATURE D. B. Longford		25. FUNERAL DIRECTOR'S SIGNATURE West Funeral Home Blue Springs		ADDRESS MO	
--	--	--	--	---	--	----------------------	--

(Licensed Embalmer's Statement on Reverse Side)

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

7-200

RAW

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..... *R. B. Burt*

Licensed Embalmer No. *23*

P. O. Address *Blue Springs*

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.