

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

44896

12123

FILED JAN 31 1957

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give town or township) St. Louis,		c. LENGTH OF STAY (in this place) 4 mo 1 day		c. CITY OR TOWN St. Louis,		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 St. Louis Chronic Hospital				e. STREET ADDRESS (If rural, give location) 257 615 Walnut-Annex Hotel.			
3. NAME OF DECEASED (Type or Print) a. (First) James			b. (Middle) Patrick		c. (Last) Tracy.		4. DATE OF DEATH (Month) (Day) (Year) December 31, 1956
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single		8. DATE OF BIRTH Jan, 27, 1895	9. AGE (In years last birthday) 61	IF UNDER 1 YEAR Months 11 Days 29	IF UNDER 24 HRS. Hours 20 Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Filling Station Att.		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) St. Louis. Mo.		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME John Tracy			13b. MOTHER'S MAIDEN NAME Mary ? Larner		14. NAME OF HUSBAND OR WIFE none		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY (If yes, give war or dates of service) 495-18-3881		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Hospital Records-5800 Arsenal St.			
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Adenocarcinoma of Left Lung ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH 1 yr.
19a. DATE OF OPERATION 3-12-56		19b. MAJOR FINDINGS OF OPERATION Adenocarcinoma of Lung				20. AUTOPSY? 2 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) 162x			
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 Aug. 8, 1956 , to Dec. 31, 1956 , that I last saw the deceased alive on Dec. 31, 1956 , and that death occurred at 8,45P m. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) John Nuderwan, M.D.				23b. ADDRESS 5800 Arsenal, St. Louis		23c. DATE SIGNED 1-2-57	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 1/4/57.	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis Mo.		
DATE REC'D BY LOCAL REG. JAN 3 1957		REGISTRAR'S SIGNATURE Carl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE W.D. Cullen Kelly		ADDRESS 7267 Natural Bridge	

(Licensed Embalmer's Statement on Reverse Side)

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

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 *James A. Lammers*.....

Licensed Embalmer No...*419*.....

P. O. Address *St. Louis*.....

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.