

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-018477

FILED VS MAY 31 1960

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STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>Buchanan</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph</b>	Length of stay in 1b <b>75yrs</b>	c. CITY OR TOWN <b>St. Joseph,</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>D.O.A. Mo. Meth. Hosp.</b>		d. STREET ADDRESS <b>2428 So 4th</b>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) <b>Cornelius Tracy</b>	4. DATE OF DEATH Month <b>May</b> Day <b>16</b> Year <b>1960</b>
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>May 1, 1885</b>	9. AGE (last birthday) <b>75yrs</b>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HR Months _____ Days _____ Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Street Dept,</b>	11. BIRTHPLACE (City and state or country) <b>Nodway Mo</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Con Tracy</b>	13b. MOTHER'S MAIDEN NAME <b>Unk</b>	14. NAME OF HUSBAND OR WIFE <b>Jeanettie Tracy</b>
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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) <b>no</b>	16. SOCIAL SECURITY NO. <b>491-10-4631</b>	17. INFORMANT <b>Jeanettie Tracy</b> Address <b>St. Joseph, Mo</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b>		INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DOE TO (b) <b>Arteriosclerotic Heart Disease</b>		<b>4 years</b>
	DOE TO (c) <b>Arteriosclerosis</b>		<b>unknown</b>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____
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21. I attended the deceased from 2/25/56 to 5/16/60 and last saw him alive on 5-3-60  
Death occurred at 10:30 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>Sharon E. Waggoner M.D.</i>	22b. ADDRESS <b>301 Illinois Ave St. Joseph, Missouri</b>	22c. DATE SIGNED <b>5/18/60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>5/20/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cemetery</b>	23d. LOCATION (City, town, or county) <b>St. Joseph, Mo</b>
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24. FUNERAL DIRECTOR <i>John E. ...</i>	ADDRESS <b>Joseph, Mo</b>	25. DATE RECD. BY LOCAL REG. <b>May 20, 1960</b>	26. REGISTRAR'S SIGNATURE <i>Mr. Clark Goodell</i>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF S.E. Waggoner, M.D. MEDICAL CERTIFICATION

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed \_\_\_\_\_

Licensed Embalmer No. 3986

P. O. Address St. Joseph

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.