

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-048382

FILED VS. JAN 9 1961 317

STATE FILE NUMBER

Registration District No. 590 Primary Registration District No. 3662 Registrar's No. 3662

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Beverly Hills</u>		Length of stay in 1b <u>8-yrs.</u>	c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>6025 New Bridge Road Mother of Good Council N. Home</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>4064 Blaine Ave.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Maria</u> Middle <u>Tracy</u> Last			4. DATE OF DEATH Month <u>December</u> Day <u>18th.</u> Year <u>1960</u>		
--	--	--	---	--	--

5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1/1/1871</u>	9. AGE (last birthday) <u>89</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>
------------------	----------------------------	--	----------------------------------	----------------------------------	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fatcort worker, Liggett</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Meyers Co.</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>
--	---	--	---

13a. FATHER'S NAME <u>Michael Tracy</u>	13b. MOTHER'S MAIDEN NAME <u>Julia Griffen</u>	14. NAME OF HUSBAND OR WIFE
---	--	-----------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, <u>no</u> unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u> </u>	17. INFORMANT <u>Mr. Joseph Byrnes, 8153 Edna Street</u>
---	-----------------------------------	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Arteriosclerosis</u>	
	DUE TO (c) <u> </u>	
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

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.) <u>none</u>
--	---	---

20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u> </u>	Month, Day, Year <u> </u> <u> </u> <u> </u>
---	---

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>none</u>	20f. CITY, TOWN, OR LOCATION <u> </u> COUNTY <u> </u> STATE <u> </u>
---	---	---

21. I attended the deceased from Feb 1953 to Dec 18 60 and last saw her alive on Dec 17. 60
Death occurred at 11:00 am. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>M Estachle</u> (Degree or title) <u>MD</u>	22b. ADDRESS <u>7124 Natural Bridge</u>	22c. DATE SIGNED <u>12-19-60</u>
--	---	----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>12/21/1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>	23d. LOCATION (City, town, or county) <u>St. Louis, Missouri</u> (State)
--	-----------------------------	--	--

24. FUNERAL DIRECTOR <u>Arthur J. Romello</u> ADDRESS <u>3840 Lindell Blvd.</u>	25. DATE RECD. BY LOCAL REG. <u>12-20-60</u>	26. REGISTRAR'S SIGNATURE <u>J. B. Murphy, M.D.</u>
---	--	---

DOCUMENT

MEDICAL CERTIFICATION

AFFIDAVIT OF

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. 469

P. O. Address 3840

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.