

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-020498  
STATE FILE NUMBER

AMENDED

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 610

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

FILED JUN 19 1961

|   |   |   |  |
|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY Buchanan   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE Mo b. COUNTY Buchanan   |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN St. Joseph   |   | Length of stay in 1b<br>6hrs  | c. CITY OR TOWN St. Joseph, Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                  |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION<br>Mo. Methodist Hospital   |   | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   | d. STREET ADDRESS (If outside, give location)<br>211 W Colo Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br>Retha Marie Tracy   |   |   | 4. DATE OF DEATH<br>Month Day Year<br>June 12, 1961  |
| 5. SEX<br>Female  | 6. COLOR OR RACE<br>White   | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>   | 8. DATE OF BIRTH (last birthday)<br>June 11, 1961  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>none   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br>no   | 11. BIRTHPLACE (City and state or country)<br>St. Joseph, Mo   |
| 12. CITIZEN OF WHAT COUNTRY<br>U.S.A.   |   | 13a. FATHER'S NAME<br>Charles Tracy   | 13b. MOTHER'S MAIDEN NAME<br>Elizabeth Fattig  |
| 14. NAME OF HUSBAND OR WIFE<br>none   |   | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br>no  | 16. SOCIAL SECURITY NO.<br>none  |
| 17. INFORMANT<br>Charles Tracy, St. Joseph, Mo  |   | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Failure of Foreman Ovale to close<br>DUE TO (b) Premature Birth<br>DUE TO (c)<br>CONDITIONS, IF ANY, WHICH GAVE RISE TO ABOVE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br>PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |  |
| 19. WAS AUTOPSY PERFORMED?<br>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.)  |  |
| 20c. TIME OF INJURY<br>Hour a.m. p.m.<br>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.)<br>6-11-61  |   | 20f. CITY, TOWN, OR LOCATION COUNTY STATE<br>St. Joseph Buchanan Mo   |  |
| 21. I attended the deceased from 3:30 P.M. to 6/12/61 and last saw her alive on 6-12-61<br>Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated. |   | 22a. SIGNATURE (Degree or title)<br>John G. Swails M.D.   |  |
| 22b. ADDRESS<br>Wathena, Kansas   |   | 22c. DATE SIGNED<br>6-12-61   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |   | 23b. DATE<br>6/13/61  | 23c. NAME OF CEMETERY OR CREMATORY<br>Green Cemetery   |
| 23d. LOCATION (City, town, or county)<br>St. Joseph, Mo   |   | 23e. STATE<br>(State)   |  |
| 24. FUNERAL DIRECTOR<br>John E. Stupp   |   | 25. DATE RECD. BY LOCAL REG.<br>June 16, 1961   |  |
| 26. REGISTRAR'S SIGNATURE<br>Mrs. Clark Goodell   |   |   |  |

MEDICAL CERTIFICATION  
J.G. Swails, M.D.

**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 body was not embalmed, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

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

Signed John E. Repp

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.