

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-047428

AMENDED

DATE AMENDED

INSTEAD OF

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3362 STATE FILE NUMBER

FILED DEC 18 1961

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Oakland		Length of stay in lb 3 months	c. CITY OR TOWN Clayton Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Bethesda-Dilworth Home		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 142 N. Central Ave. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last MARIAN W TRACY			4. DATE OF DEATH Month November Day 27 Year 1961
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1/14/77
9. AGE (last birthday) 84		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY HOME	11. BIRTHPLACE (City and state or country) St. Charles, Mo.
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME John T. Powell	
13b. MOTHER'S MAIDEN NAME Anna Nelson		14. NAME OF HUSBAND OR WIFE Joshua L. Tracy	
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 Elizabeth Schreiber Address 402 N. Central, Clayton Mo.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma descending colon Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. 8 ms DUE TO (b) Arteriosclerotic vascular disease chr. DUE TO (c) _____ 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"/> N <input type="checkbox"/> Unknown			INTERVAL BETWEEN ONSET AND DEATH
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.)	
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
21. I attended the deceased from Aug 15 1961 to Nov 27 1961 and last saw her Nov 26 1961 and last saw him Nov 26 1961 . Death occurred at 1 15 A m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Od Sheabaugh M.D.		22b. ADDRESS Webster Groves Mo	22c. DATE SIGNED 11/27/61
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 11/28/61	23c. NAME OF CEMETERY OR CREMATORY Bellefontaine Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis, Mo.
24. FUNERAL DIRECTOR Louis H. Bopp, Inc., Kirkwood, Mo.		25. DATE RECD. BY LOCAL REG. 11-27-61	26. REGISTRAR'S SIGNATURE John B. Murphy 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 _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Francis J. Wyland

Licensed Embalmer No. 4512

P. O. Address Highwood, Mo.

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.