

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

15139

File No. **2007**

**1. PLACE OF DEATH**

County Jackson  
Township Raw  
City Kennett (No. 7801 Troost av)

Registration District No. 399  
Primary Registration District No. 1002

Registered No. \_\_\_\_\_  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Pearl A. Murray

(a) Residence. No. 7801 Troost St., \_\_\_\_\_ Ward. \_\_\_\_\_  
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Fe 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Clifford M. Murray

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug-8-1888

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
44 | 9 | 7

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work Housework  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
(c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois

10. NAME OF FATHER Jack Stuart

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) North Carolina

12. MAIDEN NAME OF MOTHER Lotha Steed

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Kentucky

14. INFORMANT Clifford M. Murray  
(Address) 7801 Troost av

15. May 16 1927 M.D. M. M. Crowe REGISTRAR West

**3 MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) May-15-1927

17. I HEREBY CERTIFY, That I attended deceased from 5-12-27 1927, to 5-15-27 1927, and that I last saw him alive on 5-15-27 1927, and that death occurred, on the date stated above, at 10:45 AM.

18. THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Septic meningitis following middle ear infection  
92A  
870  
CONTRIBUTORY (SECONDARY) Mitral Insufficiency  
(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18. WHERE WAS DISEASE CONTRACTED? 900  
IF NOT AT PLACE OF DEATH? \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_

19. WHAT TEST CONFIRMED DIAGNOSIS? (Signed) Carl Jackson M. D.  
576, 1927 (Address) 573 Cornum

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Oak Grove, Mo DATE OF BURIAL May 18 1927

20. UNDERTAKER Mrs. C. L. Foster ADDRESS K. E. Mo.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

