

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

Do not use this space.

29070

1. PLACE OF DEATH

County..... Registration District No. **791** File No.
 Township..... Primary Registration District No. **1003** Registered No. **8657**
 City *St. Louis Mo* (No. **4546**) *Labadie Ave*, St. (Ward)

2. FULL NAME

Edward W. Murray
 (a) Residence No. **4546 Labadie Ave** Ward **10** (If nonresident give city or town and State)
 (Usual place of abode)
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Married*
 6. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Hulda S. Murray*
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) *June 16, 1873*
 7. AGE YEARS *54* MONTHS *3* DAYS *13* If LESS than 1 day, hrs. or min.
 8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work *Accountant*
 (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) *Canada*
 10. NAME OF FATHER *Edw. W. Murray*
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *Canada*
 12. MAIDEN NAME OF MOTHER *Not known*
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) *Canada*

14. INFORMANT *Mrs. Hulda Murray*
 (Address) *4546 Labadie Ave*

15. FILED *SEP 25 1927* *Man C. Starck* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Sept. 28 1927*
 17. I HEREBY CERTIFY, That I attended deceased from *Jan 1st 1925*, to *Sept 28th 1927*, that I last saw him alive on *Sept 28th 1927*, and that death occurred, on the date stated above, at *10:30 A.M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

*Paralysis involving
 vital centers
 Paralysis of the spine
 25 (duration) 2 yrs. mos. da.*

CONTRIBUTORY (SECONDARY) *76* (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRAINED IF NOT AT PLACE OF DEATH? *76*

19. DID AN OPERATION PRECEDE DEATH? DATE OF WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS (Signed) *Charles H. Nell*, M. D. (Address) *4546 Labadie Ave*

*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 *St. Peters* DATE OF BURIAL *Sept. 30 1927*

20. UNDERTAKER *Walter Hermann & Son* ADDRESS *4103 West Florissant Ave*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PERMANENT RECORD

