

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

Do not use this space.

38587

**1. PLACE OF DEATH**

County.....

Registration District No. 791

Township St. Louis

Primary Registration District No. 1003

City St. Louis

(No. En Route to City Hospital)

File No. ....

Registered No. 11270

St. .... Ward

**2. FULL NAME**

Thomas Murreau

(a) Residence. No. 535 W. Jefferson St. 21 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. 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) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unknown

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. abt 56 - ✓

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work Shop Worker  
(b) General nature of industry, business, or establishment in which employed (or employer) Hamilton-Brown  
(c) Name of employer

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

10. NAME OF FATHER Patrick Murreau

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

12. MAIDEN NAME OF MOTHER Kate Cologan

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

14. INFORMANT Mrs. Mice  
(Address) Milwaukee Wis

15. FILED C 17, 1927 Mar. 6 Starckoff  
Register

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec. 12 1927

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19..... that I last saw h..... alive on..... 19..... and that death occurred, on the date stated above, at 7:20 P. m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Lobar Pneumonia  
(duration) ..... yrs. .... mos. .... da.

CONTRIBUTORY (SECONDARY) WMA  
(duration) ..... yrs. .... mos. .... da.

18. WHERE WAS DISEASE CONTRACTED WMA  
IF NOT AT PLACE OF DEATH.....

18 DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY Yes

WHAT TEST CONFIRMED OF DIAGNOSIS

(Signed) [Signature] M. D.  
1927 Address [Address]

\*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 Post Lawn DATE OF BURIAL 12/19 1927

20. URDERTAKER Southern U. S. Co. ADDRESS 1315 S. Brown

WRITE PERFECTLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

