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

Do not use this space.

1451

1. PLACE OF DEATH
County Jackson — Registration District No. 399 — File No. 60
Township Raw — Primary Registration District No. 3002 — Registered No. 5
City Kansas City (No. Old City Hospital St. Ward)

2. FULL NAME Clarence Murray
(a) Residence. No. 931 Michigan 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.

48 10 9

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.

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: Col
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): June 16, 1912
7. AGE — Years: 16 | Months: 6 | Days: 15 | If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Schoolboy
(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) Kansas
PARENTS
10. NAME OF FATHER John Murray
11. BIRTHPLACE OF FATHER (CITY OR TOWN): (STATE OR COUNTRY) Mo.
12. MAIDEN NAME OF MOTHER Katie Murk
13. BIRTHPLACE OF MOTHER (CITY OR TOWN): (STATE OR COUNTRY) Mo.
14. INFORMANT Katie Tucker
(Address) 931 Michigan
15. FILED 1/4, 19 29 M. M. Jones Asst. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 1-1-1929
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.....m.
THE CAUSE OF DEATH* WAS AS FOLLOWS:
Epidemic Cerebro Spinal
Meningitis (duration) 1 yrs. ..... mos. ..... ds.
CONTRIBUTORY (SECONDARY)
..... (duration) ..... yrs. ..... mos. ..... ds.
18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Autopsy
(Signed) ....., M. D
1/1/29, 19 (Address) Deputy Coroner

*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: Maple Hill — DATE OF BURIAL: 1/5 1928.
20. UNDERTAKER: Watkins Bro — ADDRESS 1729 Lydia