

OCT 31 1930

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

Do not use this space.

30605

1. PLACE OF DEATH

County New Madrid Registration District No. 683  
Township ..... Primary Registration District No. 4357  
City Morehouse, Mo. (No. ....) (St. .... Ward)

File No. ....  
Registered No. 12

2. FULL NAME

Margaret Elizabeth Murry  
(a) Residence, No. .... St. .... Ward. Morehouse, Mo.  
(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 Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 6, 1859

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
71 | 6 | 23 | = min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife  
(b) General nature of industry, business, or establishment in which employed (or employer) .....  
(c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN) Viana, Ill.  
(STATE OR COUNTRY)

10. NAME OF FATHER Abram Wommack

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Hardin Co. Illinois  
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Anna Jones

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Kellman's Landing, Ill.  
(STATE OR COUNTRY)

14. INFORMANT Mrs. Bob Ghombery  
(Address) Cairo, Ill.

15. FILED 9-30-30 John J. Cassin  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 29 1930

17. I HEREBY CERTIFY, That I attended deceased from Sept 19, 1930 to Sept 29, 1930, and that I last saw him alive on Sept 28, 1930, and that death occurred, on the date stated above, at 7:45 m.

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

Chronic myocarditis  
Chronic atherosclerotic  
nephritis (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY)

1211W

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH? no. DATE OF.....

20. WAS THERE AN AUTOPSY? no.

21. WHAT TEST CONFIRMED DIAGNOSIS? Physical Exam

(Signed) Howard H. Kendy, M. D.

22. 9-30, 1930 (Address) Sebaston, Mo.

\*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.

23. PLACE OF BURIAL, CREMATION, OR REMOVAL Sebaston Mo. DATE OF BURIAL 9-30-30

24. UNDERTAKER ADDRESS

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

THE SECRETARY OF THE INTERIOR  
WASHINGTON, D. C. 20540

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County New Madrid Registration District No. 603 File No. \_\_\_\_\_  
 Township \_\_\_\_\_ Primary Registration District No. 4357 Registered No. 12  
 City Morehouse St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Margaret Elizabeth Murry  
 (a) Residence No. \_\_\_\_\_ 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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) wid

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

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

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

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work \_\_\_\_\_  
 (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) \_\_\_\_\_

10. NAME OF FATHER \_\_\_\_\_

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

12. MAIDEN NAME OF MOTHER \_\_\_\_\_

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

14. INFORMANT \_\_\_\_\_  
 (Address) \_\_\_\_\_

15. FILED 9-30-1930 John T. Parnis REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 29 1930

17. I HEREBY CERTIFY That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

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

\_\_\_\_\_ (duration) \_\_\_\_\_ 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? \_\_\_\_\_  
 WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_  
 (Signed) \_\_\_\_\_, M. D.  
 \_\_\_\_\_, 19\_\_\_\_ (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 \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_

20. UNDERTAKER John T. Parnis ADDRESS Morehouse Mo

N. B.—Every item of information should be carefully supplied. AGE, if not stated, should be stated. Exact statement of OCCUPATION is very important. Exact statement of OCCUPATION is very important. FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW REGISTRAR

SUPPLEMENTARY

S-30605