

WRITE PLAINLY, 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.

JUN 5 1936

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

Do not use this space.

17955

1. PLACE OF DEATH

County..... Registration District No. **791**  
Township..... Primary Registration District No. **1003**  
City *St. Louis Mo.* (No. *5830*) at City Hospital No. 1, St. *4781* Ward

2. FULL NAME

*Dr. John Murray* (Murray)  
(a) Residence, No. *5830 Enright Ave.* St. *5* Ward. (If nonresident, give city or town and State)  
(Usual place of abode)  
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 <i>Male.</i>	4. COLOR OR RACE <i>White</i>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <i>Married.</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <i>Unknown</i>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <i>Unknown - 1884</i>		
7. AGE	YEARS	MONTHS
	<i>52.</i>	<i>-</i>
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <i>Sanitor</i>		9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. <i>5830 Enright</i>
10. Date deceased last worked at this occupation (month and year)		11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Indianapolis Ind.*

13. NAME *John Murray*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Indianapolis Ind.*

15. MAIDEN NAME *Bessie Cory*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Indianapolis Ind.*

17. INFORMANT (ADDRESS) *Mrs. Paul Van. Tyngh. 36 7/2 Pleasant St. St. Louis Mo.*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Indianapolis Ind.* DATE *May 2 - 1936*

19. UNDERTAKER (ADDRESS) *Edith E. Ambrose 4334 Manchester Ave.*

20. **MAY 1 1936** *J. F. Bredeck* Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *April 30 1936*

22. I HEREBY CERTIFY, That I attended deceased from 19....., to....., 19.....  
I last saw h..... alive on....., 19..... Death is said to have occurred on the date stated above, at....., *11:20 A.*  
The principal cause of death and related causes of importance were as follows:

*Fractured Skull and Hemorrhage of Brain, received in fall down stairs at residence, 4/30/36, at about 6:30 A. M.*

Other contributory causes of importance: *None*

Name of operation..... Date of.....  
What test confirmed diagnosis?..... Was there an autopsy? *NO*

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? *Accident* Date of injury *4/30 1936*

Where did injury occur? *St. Louis, Mo.* (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place. *Home*

Manner of injury.....  
Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? If so, specify.....  
(Signed) *Frank P. Garby, M.D.*  
(Address) *Council*

