

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.

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

33034

Do not use this space.

1. PLACE OF DEATH

(a) County.....

(b) Township.....**St. Louis**

(c) City.....

Registration District No.....

Primary Registration District No.....

(d) Street No.....**City Hospital No. 1**

(If death occurred in Hospital or Institution, write its name instead of street and number)

(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

C. 8166

2. PRINT FULL NAME

Baby Murray

(a) Residence, No.....

2424 ColemanSt. **III**

(Usual place of abode, if no street address, write county or city)

(If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Und

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED, OR

single5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

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

Sept 7, 1937

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1
day, hrs.
or min.**stillborn**

OCCUPATION

8. Trade, profession, or particular kind of
work done, as sawyer, bookkeeper, etc.**nil**9. Industry or business in which work
was done, as saw mill, bank, etc.10. Date deceased last worked at
this occupation (month and
year)11. Total time (years)
spent in this
occupation12. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)**St. Louis, Missouri**

FATHER

13. NAME

Patrick Murray14. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)**St. Louis, Missouri**

MOTHER

15. MAIDEN NAME

Viola Fiebig16. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)**Missouri,**17. INFORMANT
(ADDRESS)**Hosp. Info M. Kent**

18. BURIAL, CREMATION, OR REMOVAL

PLACE

City Crematory

DATE

9/30/3719. FUNERAL DIRECTOR
(ADDRESS)**David Paul Homan**

20. FILED

SEP 29 1937**J. T. Bredeck**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR)

9/7/37

22. I HEREBY CERTIFY, That I attended deceased from

9/7/38

19.....

to.....

9/7/37

19.....

I last saw him..... alive on..... Death is said

to have occurred on the date stated above, at.....

The principal cause of death and related causes of importance were as follows:

Stillborn

Date of onset

Other contributory causes of importance:

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide?..... Date of injury....., 19.....

Where did injury occur?..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?

If so, specify.....

(Signed)....., M. D.

(Address).....

City Hospital No. 1

STATEMENT BY LICENSED EMBALMER

I, _____, Licensed Embalmer No. _____
hereby certify that the body recorded on the reverse side of this certificate was embalmed by _____
_____ L. E. _____
No. _____ or by _____, Registered Apprentice No. _____
working under my personal supervision.

Signed _____

Licensed Embalmer No. _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)