

NOV 15 1938

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

35157  
Do not use this space.

1. PLACE OF BIRTH

(a) County Bushong Registration District No. 85  
(b) Township St Joseph Primary Registration District No. 1001 Registered No. 1053  
(c) City St Joseph (d) Street No. Mo Methodist Hospital St.  
(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 7 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. 2108 So 5th St St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female  
4. COLOR OR RACE Wespa  
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Clint Murrell  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 10 1896  
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. 42 9 13  
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife  
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 occupation " "  
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Greenfield Mo.  
13. NAME Peter Gibson  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Greenfield Mo.  
15. MAIDEN NAME Gardner  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Spears Greenfield Mo.  
17. INFORMANT (ADDRESS) Clint Murrell  
2108 So 5th St  
18. BURIAL, CREMATION, OR REMOVAL PLACE City Cemetery DATE Oct 25 1938  
19. FUNERAL DIRECTOR (ADDRESS) Parsons Mortuary  
1102 Memphis St  
20. FILED Oct 25 38 W. Needleman Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 23 1938  
22. I HEREBY CERTIFY, That I attended deceased from 10/20/38, 1938, to 10/22, 1938  
I last saw h. c. r. alive on 10/23, 1938. Death is said to have occurred on the date stated above, at 7:40 a. m.  
The principal cause of death and related causes of importance were as follows:  
Acute intestinal obstruction  
Date of onset   
Other contributory causes of importance:  
Strangulation of intestine  
Peritonitis  
Name of operation Resection of ileum Date of 10/28/38  
What test confirmed diagnosis? Clinical Was there an autopsy? Yes  
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? No.  
If so, specify \_\_\_\_\_  
(Signed) Walter E. McLaughlin, M. D.  
(Address) 301 N. 8th St

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.



FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

7

35-157

Do not use this space.

1. PLACE OF DEATH

(a) County Buchanan Registration District No. 85-  
 (b) Township \_\_\_\_\_ Primary Registration District No. 1001 Registered No. 1053  
 (c) City St. Joseph (d) Street No. \_\_\_\_\_ St.  
 (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.

2. PRINT FULL NAME Edith Murrell

(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 7 4. COLOR OR RACE  negro  5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)  m

21. DATE OF DEATH (MONTH, DAY, AND YEAR)  Oct 23 1935

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

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_

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

I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
 42 9 13

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

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
 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) \_\_\_\_\_

acute intestinal obstruction caused by adhesions from previous operation n.m.o. 12213-1

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Other contributory causes of importance:  
 Gangrene of intestine Peritonitis Adhesions from previous operation n.m.o.

FATHER 13. NAME

FATHER 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME

MOTHER 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE \_\_\_\_\_ DATE \_\_\_\_\_, 19\_\_\_\_

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED \_\_\_\_\_, 19\_\_\_\_

Local Registrar.

Name of operation  Resection of Stomach  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)  Wilbur P. Mc Donald , M. D.

(Address)  301 N. 8th St. St. Joseph Mo

SUPPLEMENTARY

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

