

N. B.—Every item of information should be carefully supplied. AGE must 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

44881

Do not use this space.

1. PLACE OF DEATH
(a) County Wood Registration District No. 90-3
(b) Township South Primary Registration District No. 6211
(c) City Albion (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. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.
2. PRINT FULL NAME Lola Minnie Murray
(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

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF Sam Murray
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 10-22-1893
7. AGE YEARS 45 MONTHS 2 DAYS 9 If LESS than 1 day, _____ hrs. or _____ min.
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) Wood Co. Mo.

13. NAME John C Roberts
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

15. MAIDEN NAME Mary Rouse
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

17. INFORMANT (ADDRESS) Sam Murray
Albion Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Lotts Grove DATE 1-1-39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) St. Thomas
Bedford Mo

20. FILED 1-7-39 Fred M. M. M. (Local Registrar)

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 31 1938

22. I HEREBY CERTIFY, That I attended deceased from Dec 27 1938 to Dec 31 1938

I last saw him alive on Dec 31 1938 Death is said to have occurred on the date stated above, at _____ m.

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

telmonary thrombosis
tuberculosis
Date of onset _____

Other contributory causes of importance: 22

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) Edith A. Reed M. D.

(Address) Albion Mo

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.)

If this body is not embalmed, above space should be left blank.