

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.

REC'D AUG 11 1939

State File No. _____

Registration District No. **291**

Primary Registration District No. _____

Registrar's No. **5910**

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(c) Name of hospital or institution:
(If outside city or town limits, write "RURAL" and name of township)
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community 4929 Lansdown (Specify whether
years, months or days) 8 1/2 years in Mo. 1 1/2 years

3. (a) PRINT FULL NAME JOHN K MURRELL 641

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Emma 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Feb 17th 1859
(Month) (Day) (Year)

8. AGE: Years 81 Months 4 Days 15 If less than one day hr. _____ min. _____

9. Birthplace St. Louis Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Funeral Director

11. Industry or business _____

12. Name John P. Murrell

13. Birthplace Lynchburg Va
(City, town, or county) (State or foreign country)

14. Maiden name Emma Richmond

15. Birthplace Gelesandee
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Edna E. Murrell

(b) Address 2337 Virginia ave

17. (a) Burial (b) Date thereof 7-5-39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Valhalla Cemetery

18. (a) Signature of funeral director Murrell and Co

(b) Address 2637 Hickory

19. (a) JUL 5 1939 (b) J. P. Murrell
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County _____
(c) City or town Mo. 14
(If outside city or town limits, write "RURAL")
(d) Street No. 4929 Lansdown
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 2
year 1939 hour 5 minute P. M.

21. I hereby certify that I attended the deceased from 6/20/39
to 7/2/39, 19____; that I last saw him alive on 7-2-39, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis Duration 3 1/2 yrs
from history

Due to _____

Due to _____

Other conditions none
(Include pregnancy within 3 months of death)

Major findings: Of operations none

Of autopsy none

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury 1

23. Signature D. C. Pfeiffer (M. D. or _____)

Address 4523 J. Kingshighway (City) (State) signed 7/2/39

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

John Fetter

Licensed Embalmer No. 3880

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.