

WRITE PRINTED, 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.

1939 AUG 11 1939  
776

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

Do not use this space.

25036

1. PLACE OF DEATH 3  
 County Buchanan Registration District No. 85  
 Township 1 Primary Registration District No. 1001  
 City St. Joseph (No. State Hosp. # 2) St. \_\_\_\_\_ Ward) \_\_\_\_\_  
 607  
 2. FULL NAME Thomas Murray  
 (a) Residence, No. Buchanan Co. Hosp., St. Joseph, Mo. Ward. \_\_\_\_\_  
 (Usual place of abode) \_\_\_\_\_ (If nonresident, give city or town and State)  
 Length of residence in city or town where death occurred 2 yrs. 4 mos. 28 ds. How long in U. S., if of foreign birth? yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widowed  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF unknown  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) unknown  
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, ..... hrs. or ..... min.  
Est. 82 ? ?  
 OCCUPATION  
 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. laborer  
 9. Industry or business in which work was done, as silk mill, 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) (unk) Missouri  
 FATHER  
 13. NAME unknown  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown  
 MOTHER  
 15. MAIDEN NAME unknown  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown  
 17. INFORMANT Records State Hosp # 2  
 (ADDRESS) \_\_\_\_\_  
 18. BURIAL, CREMATION, OR REMOVAL  
 PLACE State Hosp # 2 DATE July 12, 1939  
 19. UNDERTAKER Walter Niggerhoff  
 (ADDRESS) St. Joseph, Mo.  
 20. FILED July 12, 1939 W. H. Neelbed  
 Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 8, 1939  
 22. I HEREBY CERTIFY, That I attended deceased from Nov 15, 1938, to July 8, 1939.  
 I last saw him alive on July 18, 1939. Death is said to have occurred on the date stated above, at 5:40 P.m.  
 The principal cause of death and related causes of importance were as follows:  
Diabetes Mellitus  
54  
 Other contributory causes of importance:  
Generalized Atherosclerosis  
Perirectal abscess  
 Name of operation none Date of \_\_\_\_\_  
 What test confirmed diagnosis? Chem + hab Was there an autopsy? No  
 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) W. T. O'Dell, M. D.  
 (Address) St. Joseph

STATEMENT BY LICENSED EMBALMER

I, \_\_\_\_\_, Licensed Embalmer No. \_\_\_\_\_  
hereby certify that the body recorded on the reverse side of this  
Certificate was <sup>not</sup> embalmed by \_\_\_\_\_  
or by \_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_

(Signed)

*John Anderson*  
\_\_\_\_\_  
Licensed Embalmer No. \_\_\_\_\_

**NOTE:** This statement must be signed by the licensed embalmer in his own handwriting.  
(Failure to comply with this regulation constitutes grounds for revocation of license.)