

Registration District No. **791**

Primary Registration District No. _____

Registrar's No. **439**

1. PLACE OF DEATH: **1008 FILED FEB 17 1940**

(a) County _____

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. Anthonys Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution four days
(Specify whether)

In this community Life
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town St. Louis, Missouri 17
(If outside city or town limits write "RURAL")

(d) Street No. 4205 Flad Av.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Elizabeth A. Murray **600**

8. (b) If veteran, name war No

3. (c) Social Security No. 492-03-8362

20. DATE OF DEATH: Month 1 day 15
year 1940 hour 7 minute 45 PM.

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Sept. 27, 1875
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 1-13-40
_____ 19, to 1-15-40, 19
that I last saw h. et alive on 1-15-40, 19
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day

64	3	18	hr. _____ min.
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Immediate cause of death Cerebral Apoplexy

Duration 2 da.

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

Due to _____

Due to _____

10. Usual occupation Clerk

Other conditions Chr. Myocarditis
(Include pregnancy within 3 months of death)

2 yr +

11. Industry or business Laclede Gas Light Co.

MOTHER FATHER

12. Name Patk. C. Murray

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

14. Maiden name Margaret Byrne

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

Major findings: _____

Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant Ed. S. Murray

(b) Address 4205 Flad Avenue

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? _____

17. (a) Burial (b) Date thereof Jan. 18, 40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Thos. J. Finan

(b) Address 1519 South Grand Blvd.

While at work? _____ (Specify type of place)

(c) Means of injury _____

23. Signature J. J. Ryan (M. D. or other) _____

Address 2602 So. Grand Bl. Date signed 1/15/40

19. (a) JAN 16 1940 (b) _____
(Date received local registrar)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 *Thomas J. Finnan*

Licensed Embalmer No. *11697*

P. O. Address *1579 Strand*

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 439

Registrar's No. 439

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 791

Primary Registration District No. 1003

1. PLACE OF DEATH:

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

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME Elizabeth A Murray

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

4. Sex FEMALE 5. Color or race W 6. (a) Single, widowed, married, divorced 8

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

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 64 Months 3 Days 18 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

12. Name

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

14. Maiden name

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

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address APR 3 10 10 J. F. Brebeck

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month 1 day 13 year 1940 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19

that I last saw him alive on 19 and that death occurred on the date and hour stated above.

Immediate cause of death

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

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

23. Signature J. J. Ryan (M. D. or other)

Address Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTAL COPY

