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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED JUN 2 1940

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 19731

Registration District No. 39 Primary Registration District No. 4510 Registrar's No. 3

03

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

1. PLACE OF DEATH

(a) County Stoddard  
(b) City or town Essex mo  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: W  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_ years, months or days 6 5 2  
8. (a) PRINT FULL NAME Mary Belle Murray

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

4. Sex Female 5. Color or race white 6. (a) Single, divorced, widowed, or married  
6. (b) Name of husband or wife James Murray 6. (c) Age of husband or wife if alive 63 years  
7. Birth date of deceased Oct 13 - 18 73  
(Month) (Day) (Year)

8. AGE: Years 66 Months 6 Days 25 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Home keep-

11. Industry or business \_\_\_\_\_

12. Name Adrian Allsup 13. Birthplace Tenn.  
(City, town, or county) (State or foreign country)

14. Maiden name Martha Kirk 15. Birthplace Bloomfield mo  
(City, town, or county) (State or foreign country)

16. (a) Informant Ada Morris (b) Address Essex mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-7-40  
(Month) (Day) (Year)  
(c) Place: burial or cremation Essex mo

18. (a) Signature of funeral director Walter F. ... (b) Address Dexter mo

19. (a) 5/7/40 (Date received local registrar) (b) J.P. ... (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Stoddard  
(c) City or town Essex (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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 7 year 1940 hour 4 am minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from May 7 1940 to May 7 1940  
that I last saw him alive on May 7 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Apoplexy Duration \_\_\_\_\_

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_ Of autopsy \_\_\_\_\_  
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? 754  
(Specify type of place) While at work? \_\_\_\_\_ Means of injury \_\_\_\_\_

23. Signature ... (M. D. or other) \_\_\_\_\_ Address \_\_\_\_\_ Date signed \_\_\_\_\_

RECEIVED

District Health Officer No. 2,

District File Number 640-116

Date Filed 6/20/40

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.....

Virgil H. Kelch....., Registered Apprentice No.....  
working under my personal supervision.

Signed Virgil H. Kelch.....

Licensed Embalmer No. 4102.....

P. O. Address Dexter, Mo......

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. 19731

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 839

Primary Registration District No. 45-10

Registrar's No.

ROWENA MOORE

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

1. PLACE OF DEATH

(a) County Stoddard  
(b) City or town Forest  
(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..... (Specify whether  
In this community..... years, months or days)

3. (a) PRINT FULL NAME

Mary Belle Murray

3. (b) If veteran, name war.....

3. (c) Social Security No.....

4. Sex 7

5. Color or race w

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

6. (b) Name of husband or wife.....

6. (c) Age of husband or wife, if alive 65 year

7. Birth date of deceased.....

(Month)

(Day)

(Year)

8. AGE:

Years

Months

Days

If less than one day

66

6

25

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)..... (b) Date thereof.....

(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a)..... (b).....

(Date received local registrar)

(Registrar's signature)

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.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month May day 7  
year 1950 hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....; that I last saw h..... 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.....

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.....

23. Signature W. J. Huff (M. D. or other).....

Address Forest Date signed.....

SUPPLEMENTAL

