

Registration District No. 109 Primary Registration District No. 5-158 State File No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:  
(a) County Callaway  
(b) City or town New Bloomfield  
(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 All of life  
years, months or days

3. (a) PRINT FULL NAME Mattie Branham Murray  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife W. M. Murray 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased 11 3 1858  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
81 7 26 hr. \_\_\_\_\_ min.

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

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_  
12. Name Joseph Murray  
18. Birthplace Callaway Missouri  
(City, town, or county) (State or foreign country)  
14. Maiden name Mary C. Branham  
15. Birthplace Callaway Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Lucy Robertson  
(b) Address Sturgeon, Missouri.

17. (a) Burial (b) Date thereof 7/1/1940  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation New Bloomfield, Mo.

18. (a) Signature of funeral director Ray A. Holt  
(b) Address New Bloomfield, Missouri.

19. (a) June 29-1940 (b) E. M. O. Rush  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Callaway.  
(c) City or town New Bloomfield  
(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 June day 29  
year 1940 hour 9 minute 45 A. M.

21. I hereby certify that I attended the deceased from June 9, 1940, to June 29, 1940;  
that I last saw him alive on June 29, 1940;  
and that death occurred on the date and hour stated above.

Immediate cause of death Intoxication of Alcohol Duration June 25-1940  
with Peritonitis

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

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

Other conditions Fracture of left femur  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations None

Of autopsy M

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? 108

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

28. Signature E. M. O. Rush (M. D. or other) \_\_\_\_\_

Address New Bloomfield, Mo Date signed June 24-40

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

19412  
412

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**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 Ray A. Holt

Licensed Embalmer No. 2603

P. O. Address New Bloomfield, Pa.

**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

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. **21367**

Registration District No. **109**

Primary Registration District No. **2128**

Registrar's No. \_\_\_\_\_

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

1. PLACE OF DEATH:

(a) County **Callaway**  
(b) City or town **Cedar Mt.**  
(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

**Mattie Branham Murray**

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

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **wid**

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ year \_\_\_\_\_

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

8. AGE: Years **81** Months **7** Days **26** 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) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)

(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 **June** day **29**  
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 **Intestinal Obstruction**  
Due to **N M D**

Other conditions **fracture of left femur**  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy **172 P**

PHYSICIAN  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: **not caused by**

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence **June 9 - 1940**

(c) Where did injury occur? **New Bloomfield Calloway Mo.**  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
**Death was not caused from all**  
(Specify type of place) \_\_\_\_\_

While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature **E. M. Rupp** (M. D. or other) \_\_\_\_\_  
Address **New Bloomfield** Date signed **no**

SUPPLEMENTAL

