

SEP 16 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 28019
Registrar's No. 923

Registration District No. 85

Primary Registration District No. 1001

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1515 S. 10th Street
(If not in hospital or institution, write street number or location) 2
(d) Length of stay: In hospital or institution None
(Specify whether years, months or days) 79 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan
(c) City or town St. Joseph
(If outside city or town limits, write "RURAL")
(d) Street No. 1515 S. 10th
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

8. (a) PRINT FULL NAME Margaret M. Murray (M)

8. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Female 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 February 28 1861
(Month) (Day) (Year)

8. AGE: Years 79 Months 5 Days 22 If less than one day _____ hr. _____ min.

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

10. Usual occupation At Home

11. Industry or business _____

12. Name Thomas Murray

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

14. Maiden name Unknown

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

16. (a) Informant John D. Hartigan

(b) Address 1515 S. 10th Str. St. Joseph, Mo

17. (a) Burial (b) Date thereof Aug. 20 1940
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Olivet Cemetery

18. (a) Signature of funeral director H.O. Sidenfaden & Son

(b) Address 1802 Union Str. St. Joseph, Mo.

19. (a) 8-22-1940 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 20th
year 1940 hour 4 minute 20 P.M.

21. I hereby certify that I attended the deceased from June 5 1940 to Aug 20 1940.
that I last saw her alive on Aug 20 1940
and that death occurred on the date and hour stated above.

Immediate cause of death: Broncho-pneumonia Aug 19/40
Duration

Due to 12 3 W

Due to _____
Other conditions: Pyelitis - Severe June 40
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: None
Of operations: None
Of autopsy: No
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?
85

23. Signature [Signature] (Specify type of place) While at work (e) Means of injury _____
Address [Signature] Date signed 8/20/40

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

11
5
7

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 Robert P. Clarkson

Licensed Embalmer No. 4028

P. O. Address St. Joseph, 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.