

Registration District No. 538

Primary Registration District No. 5721

Registrar's No. 76

1. PLACE OF DEATH:

(a) County Madison  
(b) City or town New Coldwater, Ind.  
(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 institution)

In this community \_\_\_\_\_ years, months or days

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

4. Sex M 5. Color or race W  
6. (a) Single, widowed, married, divorced \_\_\_\_\_

6. (b) Name of husband or wife \_\_\_\_\_  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Sept 22 1940  
(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months 1 Days 15  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Madison Co. - New Coldwater  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

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

12. Name Otto Murray  
13. Birthplace Coldwater, Mo  
(City, town, or county) (State or foreign country)  
14. Maiden name Marquette Phelps  
15. Birthplace New Coldwater, Mad. Co. Mo  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature James J. ...  
(b) Address Coldwater, Mo

17. (a) Burial (b) Date thereof Nov 18, 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Coldwater, Mo

18. (a) Signature of funeral director E. H. Webb  
(b) Address Madison, Mo

19. (a) Nov 18, 1940 (b) S. C. S. Laughlin  
(Date received local registrar) (Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Madison  
(c) City or town Rural Twelve mile  
(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.

FILED DEC 11 1940

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 17  
year 1940 hour 6 minute 30 P. M.

21. I hereby certify that I attended the deceased from Birth to Nov 17, 1940  
this attack - 1940, to Nov 17, 1940  
that I last saw him alive on Nov. 16 - 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia  
Left Lung Bronchial  
Duration ✓

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

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

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy none

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 M. P. Parker (M. D. certifying) M. D.  
Address Fredonia, Mo Date signed 11-18-40

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

167A

**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.....

*Was not embalmed*

....., Registered Apprentice No.....

working under my personal supervision.

Signed *Ed. H. Webb*

Licensed Embalmer No. *731*

P. O. Address *Fredericktown, Md*

**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.**

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

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. 39192  
Registrar's No. 76

Registration District No. 538

Primary Registration District No. 5721

**1. PLACE OF DEATH:**  
 (a) County Madison  
 (b) City or town Coldwater, T.P.  
 (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 \_\_\_\_\_ (Specify whether  
 years, months or days)

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced \_\_\_\_\_

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 \_\_\_\_\_ Months 15 Days \_\_\_\_\_ If less than one year \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

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

MOTHER FATHER { 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 11 day 17 year 1940 hour 9:30 minute A M.  
 21. I hereby certify that I attended the deceased from 9/16/40 to 9/17/40 that I last saw him alive on 9/16/40 and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia  
Left lung Bronchial  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions Bronchitis - for few days  
 (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 M. B. Barber (M. D. or other) \_\_\_\_\_  
 Address Fredricks town, Mo. Date signed \_\_\_\_\_

SUPPLEMENTAL

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

S-39192 1940