DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 24553

Registrar's No. 743

Primary Registration District No. 1001

...on District No. 85

FILED 6 11 1941

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

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: Mo. Methodist Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 Days. (Specify whether

In this community "0" years, months or days)

2. USUAL RESIDENCE OF DECEASED: 025

(a) State Mo. (b) County Clinton

(c) City or town Cameron (If outside city or town limits, write "RURAL")

(d) Street No. 406 N. Walnut (If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME THOMAS MURRAY

3. (b) If veteran, name war none

3. (c) Social Security No. none

4. Sex male 0

5. Color or race White

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

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

6. (c) Age of husband or wife if alive 74 years

7. Birth date of deceased Feb. (Month) 4th. (Day) 1851 (Year)

8. AGE: Years	Months	Days	If less than one day
90	5	18	hr. min.

9. Birthplace Richmond (City, town, or county) Mo. (State or foreign country) 0

10. Usual occupation News Paper Salesman

11. Industry or business

FATHER
12. Name Thomas Murray
13. Birthplace Richmond (City, town, or county) Mo. (State or foreign country) 0

MOTHER
14. Maiden name Drucella James
15. Birthplace Richmond (City, town, or county) Mo. (State or foreign country) 0

16. (a) Informant Mrs. Josephine Murray

(b) Address 406 N. Walnut Cameron, Mo.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 7--24--41 (Month) (Day) (Year)

(c) Place: burial or cremation Plattsburg, Mo.

18. (a) Signature of funeral director FLEEMAN & SON INC.

(b) Address St. Joseph, Mo.

19. (a) 7-24-1941 (Date received local registrar) (b) H J Nestlebush (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 22nd year 1941 hour 8.15 minute P. M.

21. I hereby certify that I attended the deceased from July 16 July 16, 1941, to July 22, 1941; that I last saw him alive on July 22, 1941; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Bilateral hypostatic bronchopneumonia	6 days.
Due to Comminuted fracture of neck of left femur	2 wks.
Due to	
Other conditions Senility (Include pregnancy within 3 months of death)	

Major findings: Of operations None

Of autopsy Permission refused.

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature Cabray Wortley (M. D. or other) (M.D.)

Address St. Joseph, Mo. Date signed 7-23-41

(Licensed Embalmer's Statement on Reverse Side)

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 Dean Owens, Registered Apprentice No. 283 working under my personal supervision.

Signed Carl W. Hause

Licensed Embalmer No. 2955

P. O. Address St. Joseph, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to compl the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

V. S. No. 2B
DM—8-21-41
J X20288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 24533

Registration District No. 85 | Primary Registration District No. 1001 | Registrar's No. 743

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

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: Mo. Methodist Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)
In this community .....

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) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME: Thomas 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: Wd
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 | Days | If less than one day ..... 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) ..... (Burial, cremation, or removal) (b) Date thereof ..... (Month) (Day) (Year)
(c) Place: burial or cremation .....
18. (a) Signature of funeral director .....
(b) Address .....
19. (a) ..... (Date received local registrar) (b) ..... (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July Day 12 year 1941 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: Bilateral Hypostatic Bronchopneumonia — Duration
Due to: Comminuted fracture of neck of left femur
Due to: Fall in home
Other conditions: Senility
(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): accident #25
(b) Date of occurrence: July 10, 1941
(c) Where did injury occur? Cameron, Clinton, Mo. (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? In farm home (Specify type of place)
While at work? No (e) Means of injury: Fall
23. Signature: Cabray Worley (M. D. or other) M.D.
Address: St. Joseph, Mo. Date signed 9-12-41

SUPPLEMENTARY