

S. No. 2
11-10-39
v. 5-17-39
I X21492

15899

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED MAY 23 1942 04

Registration District No. _____

Primary Registration District No. 2546

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Worth

(b) City or town Shepherd
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Shepherd
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 yrs. (Specify whether years, months or days)

In this community 3 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Worth

(c) City or town Shepherd
(If outside city or town limit write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME EMERY CLARENCE 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 Married

6. (b) Name of husband or wife Sarah Frances Murray 6. (c) Age of husband or wife if alive 66 years

7. Birth date of deceased July 24 1867
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>74</u>	<u>9</u>	<u>0</u>	hr. _____ min. _____

9. Birthplace Way Co. Mo. (City, town, or county) (State or foreign country)

10. Usual occupation farmer

11. Industry or business _____

12. Name Stephen Murray

18. Birthplace Wentworth Kentucky (City, town, or county) (State or foreign country)

14. Maiden name Mrs. Jane C. Murray

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

16. (a) Informant Sarah Murray

(b) Address Shepherd Mo.

17. (a) Burial (b) Date thereof 4-26-42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Grant City Cem.

18. (a) Signature of funeral director Arch C. Duffel

(b) Address Grant City Mo.

19. (a) April 30 1942 (b) Arlepe Scadden
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 24
year 1942 hour 7:30 minute _____ P. M.

21. I hereby certify that I attended the deceased from June 18 1941 to April 24 1942 that I last saw him alive on April 24 1942 and that death occurred on the date and hour stated above.

Immediate cause of death Tuberculosis

Due to myocarditis

Due to _____

Other conditions (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) (c) Means of injury 9
23. Signature B. J. Carter (M. D. or other) _____
Address Shepherd Mo Date signed 4-28-42

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

MOTHER FATHER

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

1104

(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.....

....., Registered Apprentice No.

working under my personal supervision.

Signed

Arch C. Dunfee

Licensed Embalmer No. 3252

P. O. Address Grant City, 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.