

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

No. 1
5-42
17-39
X32873

FILED AUG 9 1943

Registration District No. 354

Primary Registration District No. 6197

Registrar's No. 31

1. PLACE OF DEATH:

(a) County: TEXAS

(b) City or town: (RURAL) BURDINE TWP

(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: 71 (Specify whether years, months or days)

In this community: 71

2. USUAL RESIDENCE OF DECEASED:

(a) State: MO (b) County: Texas 107

(c) City or town: Rural Burdine Twp

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

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

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

If yes, name country: /

3. (a) PRINT FULL NAME: RILEY MURRILL

3. (b) If veteran, name war: No

3. (c) Social Security No.

4. Sex: MALE

5. Color or race: W

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: July 27 1875

(Month) (Day) (Year)

8. AGE: Years 71 Months 11 Days 27

If less than one day: / hr. / min.

9. Birthplace: / (City, town, or county) (State or foreign country)

10. Usual occupation: FARMER

11. Industry or business: /

12. Name: E. P. Murrill

13. Birthplace: Franklin Co MO (City, town, or county) (State or foreign country)

14. Maiden name: LUCY MANES

15. Birthplace: Jefferson Co MO (City, town, or county) (State or foreign country)

16. (a) Informant: Wm Skyles

(b) Address: Cabool Mo

17. (a) Burial (Burial, cremation, or removal)

(b) Date thereof: July 26 - 43 (Month) (Day) (Year)

(c) Place: burial or cremation: PHEASANT GROVE

18. (a) Signature of funeral director: Eugene Wellist

(b) Address: Cabool Mo

19. (a) July 26 - 43 (Date received local registrar)

(b) Mrs. Lou Miller (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 24 year 1943 hour / minute / M.

21. I hereby certify that I attended the deceased from / No attending physician / 19 /

that I last saw h / alive on / 19 /

and that death occurred on the date and hour stated above.

Immediate cause of death: Sugar Diabetic

Due to: /

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: /

23. Signature: P. Husband (M: D. or other) /

Address: Houston Mo Date signed: 7-24-43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

RECEIVED

District Health Officer No. 5,

District File Number

843482

Date Filed

8-6-43

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

Gaylord V. Elliott

Licensed Embalmer No.

2252

P. O. Address

Cabool 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, fact should be so stated above.

Registration District No. 354

Primary Registration District No. 6197

Registrar's No. 31

1. PLACE OF DEATH:

(a) County Jeddo
 (b) City or town Rural Burdette Sup.
 (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 Riley Merrill
 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 S

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: July 27
 (Month) (Day) (Year)

8. AGE: Years 71 Months 4 Days 10 Unless than one day _____ min.

9. Birthplace Unknown
 (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) Mrs. Lon Miller (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) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July Year 1943 Hour _____ Minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration

Due to _____

Due to _____

Other conditions (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) _____

(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. D. or other) _____

Address _____ Date signed _____

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

SUPERSEDED PERMANENTLY

S-26353