

FILED MAR 14 1944

State File No. _____

Registration District No. 328

Primary Registration District No. 3073

Registrar's No. 5

1. PLACE OF DEATH:

(a) County Scott
 (b) City or town Chaffee
(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 years, months or days)
 In this community 15 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Scott 100
 (c) City or town Chaffee
(If outside city or town limits, write "RURAL")
 (d) Street No. _____
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME William MURDOCK

3. (b) If veteran, name war ✓ 3. (c) Social Security No. ✓

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced Widower

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

7. Birth date of deceased: Sep 1, 1856
(Month) (Day) (Year)

3. AGE:	Years	Months	Days	If less than one day
	<u>87</u>	<u>5</u>	<u>7</u>	hr. min.

9. Birthplace Near Princeville Ill 1
(City, town, or county) (State or foreign country)

10. Usual occupation Former RR Engineer shoe repair man

11. Industry or business _____

12. Name Matthew MURDOCK

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

14. Maiden name Annie Appketon

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

16. (a) Informant Dr Mabel Walling
 (b) Address Chaffee Mo

17. (a) Burial (b) Date thereof 2-10-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cape Co Mo
 18. (a) Signature of funeral director Bispling Hoffhubbers
 (b) Address Chaffee Mo
 19. (a) 2-8-44 (b) Krista Erase
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 5th
 year 1944 hour 6 minutes 25 A.M.

21. I hereby certify that I attended the deceased from Feb 1 1944 to Feb 8 1944
 that I last saw him alive on Feb 6 1944
 and that death occurred on the date and hour stated above.

Immediate cause of death: Serulitis Malnutrition
 Due to Mediastinal tumor 5 yrs

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)
 (e) Means of injury 9

23. Signature J. H. Skellings (M. D. or other) MD
 Address Chaffee Mo Date signed 2/8/44

MOTHER FATHER

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

WRITE PLAINLY—USE UNFADING INK

RECEIVED

District Health Office No. 2,

District File Number 344-454

Date Filed 3-9-44

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..... Winnie Duplinsky

Licensed Embalmer No. 8242

P. O. Address..... Chaffee m

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. *328* Primary Registration District No. *3073*

1. PLACE OF DEATH:
(a) County *Scott*
(b) City or town *Chappel*
(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 *Tom Murdock*
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 *W*
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased *Sept 1916*
(Month) (Day) (Year)

8. AGE: Years *87* Months *6* Days _____ Unless than one day _____ 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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *3* Day *8* Year *1944* 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 *Senility*

Due to *malnutrition*
med. surgical tumor
(Benign)

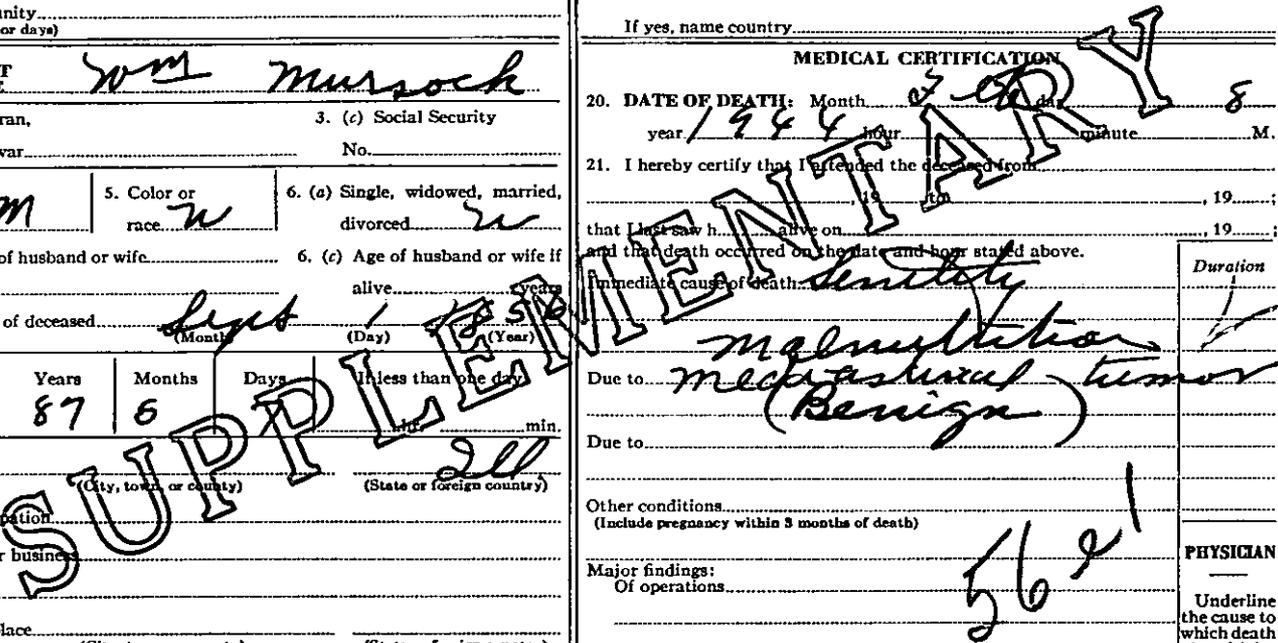
Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy _____

Duration _____
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 *H. Steilings* (M. D. or other) *DO*
Address *Deak* Date signed *3/15/44*

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



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