

U. S. No. 2  
FORM 5-43  
Rev. 5-17-39  
No. 1 X39671

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

12140

FILED MAR 20 1944  
Registration District No. 3177

Primary Registration District No. 6076

State File No. \_\_\_\_\_  
Registrar's No. 635

96  
0  
0  
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution:  
Pine Crest Nursing Home  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 1/2 months  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Laclede <sup>53</sup>

(c) City or town Falcon (Rural) <sup>0</sup>  
(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 MILBURN FRANKLIN MURRELL

MEDICAL CERTIFICATION

3. (b) If veteran, name war none

3. (c) Social Security No. none

20. DATE OF DEATH: Month March day 1  
year 1944 hour 3 minute 30 P.M.

4. Sex m 5. Color or race w

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

6. (b) Name of husband or wife Violet Henderson

6. (c) Age of husband or wife if alive 50 years

7. Birth date of deceased May 2 1891  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Nov 15, 1943, to March 1, 1944  
that I last saw him alive on Feb 29, 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic Myocarditis  
Duration \_\_\_\_\_

8. AGE: Years 52 Months 9 Days 29  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

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

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

Other conditions Bronchial Asthma  
(Include pregnancy within 3 months of death)

10. Usual occupation Farmer

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

Major findings:  
Of operations \_\_\_\_\_

Of autopsy 93d

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

12. Name B. F. Murrell

13. Birthplace Laclede Co Mo  
(City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Jane Lewis

15. Birthplace Laclede Co Mo  
(City, town, or county) (State or foreign country)

22. If death was due to external causes, fill in the following:

16. (a) Informant This Violet Murrell

(b) Address Falcon Mo

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

(b) Date thereof 3-3-44  
(Month) (Day) (Year)

(c) Place: burial or cremation Casper Cemetery

18. (a) Signature of funeral director W. E. Helman

(b) Address Lebanon Mo

(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 \_\_\_\_\_

19. (a) MAR 15 1944  
(Data received local registrar)

E. J. Mc Lerran  
(Registrar's signature)

23. Signature P. M. Jansen (M. D. or other) \_\_\_\_\_  
Address Manchester Mo Date signed 3/1/44

JUN 2 1950

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 Dorsey M. Howe  
Licensed Embalmer No. 4222  
P. O. Address Lebanon 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.