

FILED OCT 6 1944

Registration District No. 144

Primary Registration District No. 4233

Registrar's No. 5

1. PLACE OF DEATH:

(a) County Iron

(b) City or town Arcadia  
(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) 1

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Iron <sup>47</sup>

(c) City or town Arcadia <sup>0</sup>  
(If outside city or town limits, write "RURAL") <sup>0</sup>

(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 Catherine Murray

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 17  
year 1944 hour 1 minute 10 A. M.

3. (b) If veteran, name war no 3. (c) Social Security No. none

21. I hereby certify that I attended the deceased from 12-23-43  
to 9-16-44, 19\_\_\_\_; that I last saw him er alive on 9-16-44, 19\_\_\_\_; and that death occurred on the date and hour stated above.

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

Immediate cause of death acute cardiac failure <sup>9/16/44</sup>

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

7. Birth date of deceased October 16 1865  
(Month) (Day) (Year)

Due to chronic myocarditis?

8. AGE: Years 78 Months 11 Days 1 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to Dehronic Arthritis?

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

Other conditions Dehronic Arthritis  
(Include pregnancy within 3 months of death)

10. Usual occupation at home

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

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

Of autopsy \_\_\_\_\_ <sup>938</sup>

12. Name John Murray

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

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

14. Maiden name Margaret McCue

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

16. (a) Informant Charley Evans

(b) Address Arcadia Mo.

17. (a) burial (b) Date thereof 9-19-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Pilot Knob Mo.

18. (a) Signature of funeral director Norman White & Sons

(b) Address Ironton Mo.

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 P. E. Harland (M. D. or other) M.D.  
Address Ironton, Mo. Date signed 9-22-44

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

47  
00

1365

RECEIVED

District Health Officer No. 4

District File Number 1044-4370

Date Filed 10-5-44

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**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 Arnell White

Licensed Embalmer No. 3012

P. O. Address Clinton, 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.**