

No. 2
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5-17-39
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FILED OCT 15 1945

Registration District No. **302**

Primary Registration District No. **6041**

Registrar's No. **1523**

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

1. PLACE OF DEATH:
 (a) County Ripley
 (b) City or town Thomas rural
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 2 1/2 miles north of Naylor
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution life
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Carl Mc Murtry
 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 single
 6. (b) Name of husband or wife
 6. (c) Age of husband or wife if alive 1906 years
 7. Birth date of deceased Dec. 1 1945
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
38 9 22 hr. min.

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

10. Usual occupation JAMES XXXX XXXX XXXX XXXX

11. Industry or business labor

MOTHER FATHER {
 12. Name James S. Mc Murtry
 13. Birthplace Ripley Co. Mo.
(City, town, or county) (State or foreign country)
 14. Maiden name Dona Walker
 15. Birthplace Ripley Co. Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant James L. Mc Murtry
 (b) Address Naylor, Mo.

17. (a) Burial (b) Date thereof Sept. 26, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Gumm Ceme.

18. (a) Signature of funeral director Minnie Gish
 (b) Address Naylor, Mo.

19. (a) (b)
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State MO (b) County Ripley 91
 (c) City or town Naylor, Mo.
(If outside city or town limits, write "RURAL")
 (d) Street No. 0
(If rural, give location)
 (e) Citizen of foreign country? 0
(Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 23
 year 1945 hour 11:00 am minute _____ M.

21. I hereby certify that I attended the deceased from Sept 23 1945, to Sept 23 1945
 that I last saw him alive on Sept 23 1945
 and that death occurred on the date and hour stated above.

Immediate cause of death Lobar pneumonia
 Due to exposure

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

Major findings:
 Of operations _____
 Of autopsy none

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) (c) Means of injury
 23. Signature H. G. White (M. D. or Other) MD
 Address Naylor, Mo. Date signed 9/22/45

1217

RECEIVED

District Health Officer No. 5,

District File Number 1045-522

Date Filed 10-13-45

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, Bryan McArd

Licensed Embalmer No. 4979

P. O. Address Naylor, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. *oct*

Registrar's No. *10-23*

Registration District No. *302*

Primary Registration District No. *6041*

1. PLACE OF DEATH:

(a) County *Ripley*
(b) City or town *Small Thomas Twp*
(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

Carl Mcmurry

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 _____

7. Birth date of deceased *Dec 1* (Month) *19* (Day) *19* (Year)

8. AGE: Years *38* Months _____ Days _____ If less than one day, hr. _____ min. _____

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

10. Usual occupation _____

11. Industry or business _____

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 _____ (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) *Oct 1 - 45* (b) *Bertha White* (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 *Oct* Year *1945* hour _____ minute _____ M.

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

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months preceding date 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 _____

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

SUPPLEMENTARY

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

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

31315