. S. No. 2
00M—2-43
ev. 5-17-39
I X35897

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 2 1945
318

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 32220

Registration District No. ..... Primary Registration District No. 1003 Registrar's No. 9089

1. PLACE OF DEATH:

(a) County .....
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Mo. Baptist Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 Days (Specify whether years, months or days)
In this community 6 Mo.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 220
(c) City or town St. St. Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No. 7080 Mitchell 9
(If rural, give location) 0
(e) Citizen of foreign country? yes (Yes or No)
If yes, name country Scotland

3. (a) PRINT FULL NAME Jessie M. Murray

3. (b) If veteran, name war .....

3. (c) Social Security No. .....

4. Sex Fem

5. Color or race White

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

6. (b) Name of husband or wife Robert A. Murray

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

7. Birth date of deceased 10 (Month) 18 (Day) 1866 (Year)

8. AGE: Years 79 Months 0 Days 3 If less than one day ..... hr. ..... min.

9. Birthplace Edinburg Scotland (City, town, or county) 4 (State or foreign country)

10. Usual occupation house wife

11. Industry or business .....

FATHER
12. Name John Martin
13. Birthplace Scotland (City, town, or county) 4 (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace " (City, town, or county) 4 (State or foreign country)

16. (a) Informant John M. Murray
(b) Address 7080 Mitchell

17. (a) Cremation (Burial, cremation, or removal) (b) Date thereof 10-22-45 (Month) (Day) (Year)
(c) Place: burial or cremation Valhalla

18. (a) Signature of funeral director Alexander & Son.
(b) Address 6175 Delmar Blvd.

19. (a) OCT 22 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 21 year 1945 hour 3 minute 50 A.M.

21. I hereby certify that I attended the deceased from ....., 19....., to ....., 19.....; that I last saw h..... alive on ....., 19.....; and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic pneumonia
Fracture of left femur suffered when deceased fell in the bathroom
Due to Bedridden Nursing Home
2 yrs Cerebral Tumor Duration
Due to On Oct 15 1945 Deceased came unknown

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) Accident
(b) Date of occurrence Oct 15 1945
(c) Where did injury occur? Maplewood Mo (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Nursing Home (Specify type of place)
While at work? ..... (e) Means of injury as above

23. Signature Thomas F Callan M.D. (M.D. or other)
Address Coroner Date signed Oct 22 45

(Licensed Embalmer's Statement on Reverse Side)

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 Jos. E McCullah

Licensed Embalmer No. 2460

P. O. Address 6170 Delmar

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.