

FILED NOV 9 1945

Registration District No. 24

Primary Registration District No. 5839

1. PLACE OF DEATH:

(a) County Newton
(b) City or town Rural, Granby Granby, Mo
(c) Name of hospital or institution:
On Hiway #. 60, 2 Miles West Of Granby MO
(d) Length of stay: In hospital or institution _____
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Newton 73
(c) City or town Rural 0
(d) Street No. Granby MO, R.F.D. #. 0
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Edith Murray

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

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

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

7. Birth date of deceased March, 5, 1886
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
89 6 25 hr. min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name Lyman Maynard

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

14. Maiden name Sopha Daily

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

16. (a) Informant Grace Scritchfield

(b) Address Granby MO.

17. (a) Burial (b) Date thereof 10-2-1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial of Grace Cemetery

18. (a) Signature of funeral director Charles D. Williams

(b) Address Goodman mo

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 30
year 1945 hour 10. minute 50.2. M.

21. I hereby certify that I attended the deceased from Sept
1944 to Sept. 26, 1945;
that I last saw her alive on Sept. 26, 1945;
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial
Degenerative changes

Due to Generalized Arterio-
sclerosis

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 _____

23. Signature Charles D. Williams (M.D. or other) D.O.

Address Granby, Mo. Date signed 10/18/45

Duration

1 month

1 yr

13 yr

PHYSICIAN

Underline
the cause to
which death
should be
charged statistically.

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

1542

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.

RECEIVED NOV 8 1945

District Health Officer No.

Signed.....

District File Number 1045-196

Licensed Embalmer No.....

Date Filed... NOV 8 1945

P. O. Address.....

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. 247 Primary Registration District No. 5839

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

1. PLACE OF DEATH:

(a) County Newton

(b) City or town Rural Granby Twp.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
On Highway 60 2 miles West of Granby
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Newton

(c) City or town Rural
(If outside city or town limits, write "RURAL")

(d) Street No. Granby, Mo. R.F.D. #
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Edith Murray

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced wid

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

7. Birth date of deceased Mar 5
(Month) (Day) (Year)

8. AGE: Years 89 Months 6 Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name Syman Maynard

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

14. Maiden name Slopha Daily

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

16. (a) Informant Grace Scritchfield

(b) Address Granby, Mo

17. (a) Burial (b) Date thereof 10-2-1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Price Cemetery

18. (a) Signature of funeral director Chas. H. Williams

(b) Address Loddsman Mo

19. (a) 10-8-45 (b) M. L. Young
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept Day 26 Year 1945 Hour 5 Minute 50 P.M.

21. I hereby certify that I attended the deceased from Sept 26, 45 to Sept 26, 1945

that I last saw him/her alive on Sept 26, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial Ischemic Arteriosclerosis

Due to _____

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 _____

23. Signature Charles O. Chester D. or other DD

Address Granby, Mo Date signed 10-8-45

Duration 1 month

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

SUPPLEMENTAL

Ind

By E.W. Conner

34265