No. 2
5-42
5-17-39
X32873

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 15 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 34814

Registration District No. 323 Primary Registration District No. 3074 Registrar's No. 13

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

1. PLACE OF DEATH:
(a) County: Scott
(b) City or town: Sikeston
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 511 William St
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days) In this community: 35 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Scott 100
(c) City or town: Sikeston (If outside city or town limits, write "RURAL") 5
(d) Street No.: 511 Williams (If rural, give location) 2
(e) Citizen of foreign country? No (Yes or No) 0
If yes, name country: —

3. (a) PRINT FULL NAME: Fannie Murrell
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: Married
6. (b) Name of husband or wife: G. T. Murrell
6. (c) Age of husband or wife if alive: 77 years
7. Birth date of deceased: April (Month) 5 (Day) 1866 (Year)

8. AGE: Years 79 Months 2 Days 19 If less than one day ____ hr. ____ min.

9. Birthplace: Tenn (City, town, or county) 1 (State or foreign country)
10. Usual occupation: Housewife
11. Industry or business: ____
MOTHER FATHER
12. Name: unknown
13. Birthplace: unknown (City, town, or county) 9 (State or foreign country)
14. Maiden name: unknown
15. Birthplace: unknown (City, town, or county) 9 (State or foreign country)
16. (a) Informant: G. T. Murrell
(b) Address: Sikeston Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/25/45 (Month) (Day) (Year)
(c) Place: burial or cremation: Sikeston
18. (a) Signature of funeral director: Brville Taylor
(b) Address: Sikeston Mo
19. (a) 10-11-45 (Date received local registrar) (b) Mrs T. T. Henry (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 24 year 1945 hour 8 minute A. M.
21. I hereby certify that I attended the deceased from July 24 1945 to July 24 1945 that I last saw her alive on July 24 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Myocarditis	
Due to:	
Due to:	
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)
(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? (Specify type of place)
While at work? (e) Means of injury
23. Signature: [illegible] (M. D. or other)
Address: Sikeston Date signed Oct 2 45

1494 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 2,
District File Number 1045-3162
Date Filed 10-31-42

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 W. C. Cory

Licensed Embalmer No. 4399

P. O. Address Poplar Bluff

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.