S. No. 2
DM—2-43
7. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 12 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 38399

Registration District No. 316 Primary Registration District No. 4461 Registrar's No. 215

1. PLACE OF DEATH:
(a) County St Francois
(b) City or town Bismarck, Mo
(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)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Francois 94
(c) City or town Bismarck, Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. ..... (If rural, give location) 0
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME Mr William Murray
3. (b) If veteran, name war .....
3. (c) Social Security No. .....
4. Sex Male 0
5. Color or race White Caucasian
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Rhonda Staples
6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased Nov (Month) 26 (Day) 1866 (Year)

8. AGE: Years 78 Months 11 Days 13 If less than one day ..... hr. ..... min.

9. Birthplace Crawford (City, town, or county) 0 (State or foreign country)
10. Usual occupation Mechanic
11. Industry or business .....
FATHER
12. Name Mr Joseph Murray
13. Birthplace Ireland (City, town, or county) 4 (State or foreign country)
MOTHER
14. Maiden name Julia Buckley
15. Birthplace Crawford Co Mo 0 (City, town, or county) (State or foreign country)
16. (a) Informant Mrs. R. A. Kerman (daughter)
(b) Address Bismarck, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 9-1945 (Month) (Day) (Year)
(c) Place: burial or cremation I.O.O.F. Cemetery Bismarck, Mo
18. (a) Signature of funeral director Alvin W. Ford
(b) Address 30 3 Crane St. Flat River, Mo.
19. (a) 11-9-45 (Date received local registrar) (b) Esther Rudloff (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 7 year 1945 hour 2 minute P M.
21. I hereby certify that I attended the deceased from Nov-1-, 1945, to Nov. 7, 1945, that I last saw him alive on Nov. 7, 1945, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Double Lobar Pneumonia	3 dy
Due to Influenza	4
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 F. W. Gale (M. D. or other)
Address Bismarck Mo Date signed Nov. 8-45

139.1

(Licensed Embalmer's Statement on Reverse Side)

District Health Officer No. 4
District File Number 1245-1437
Date Filed 12-10-45

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 Alvin W. Hoof

Licensed Embalmer No. 2780

P. O. Address 30 3 Crane St. Flat River, 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.