

V. S. No. 2
100M-5-43
Rev. 5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

27274

3584

FILED SEP 3 1948

Registration District No.

Primary Registration District No.

1002

Registrar's No.

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: General Hospital No. 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 83 days (Specify whether years, months or days)
In this community 83 days

3. (a) PRINT FULL NAME

FRANK MURRAY

3. (b) If veteran,

name war

no

3. (c) Social Security

name none

4. Sex

Male

5. Color or race Negro

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

6. (b) Name of husband or wife

Annie Murray

6. (c) Age of husband or wife if alive 55 years

7. Birth date of deceased

April 8, 1881

(Month)

(Day)

(Year)

8. AGE:

Years

Months

Days

If less than one day

65

4

10

hr.

min.

9. Birthplace

Marshall

(City, town, or county)

Missouri

(State or foreign country)

10. Usual occupation

Farmer

11. Industry or business

12. Name

Temp Murray

13. Birthplace

(City, town, or county)

Virginia

(State or foreign country)

14. Maiden name

Frances

15. Birthplace

(City, town, or county)

Virginia

(State or foreign country)

16. (a) Informant

Annie Murray

(b) Address

Route 1, Box 111, Marshall, Mo.

17. (a)

(Burial, cremation, or removal)

(b) Date thereof

8-19-46

(c) Place: burial or cremation

Marshall Mo

18. (a) Signature of funeral director

Frederick J. Jones

(b) Address

Marshall Mo

19. (a)

(Date received local registrar)

(b) Signature

Heraldine Holmes

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Saline
(c) City or town Marshall
(If outside city or town limits, write "RURAL")
(d) Street No. Route 1, Box 111
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 19
year 1946 hour 3 minute 45 a.m.

21. I hereby certify that I attended the deceased from
May 27, 1946 to August 19, 1946
that I last saw him alive on August 19, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death

Hemisection of Cord
Paralysis of Lower Extremities

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

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) Dropped by Team of Horses about 100 ft.
(b) Date of occurrence 3/20/46
(c) Where did injury occur? Marshall, Saline, Mo.
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

On Farm

While at work

(Specify type of place)

Means of injury trauma

23. Signature

Frank Jones

(M. D. or other) M.D.

Address

600 E. 22nd Street

Date signed 3/19/46

(Licensed Embalmer's Statement on Reverse Side)

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

26115

MAR 25 1949

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.....

Licensed Embalmer No. 40220

P. O. Address. Muskegon 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.