S. No. 2
M—9-4-41
ev. 5-17-39
P I X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 31 1947

Registration District No. 42

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 8090

Primary Registration District No. 1000

Registrar's No. 415

1. PLACE OF DEATH:
(a) County Buchanan
(b) City or town St Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: State Hospital no 2.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 yrs 6 mo (Specify whether years, months or days)
In this community 6 yrs 6 month

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County City of St. Louis
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 5107 Maple Ave.
(If rural, give location)
(e) Citizen of foreign country? yes (Yes or No)
If yes, name country Born in Ireland.

3. (a) PRINT FULL NAME Frank Murray
3. (b) If veteran, name war No
3. (c) Social Security No. None
4. Sex Male
5. Color or race white
6. (a) Single, widowed, married, divorced single
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased non given (Month) (Day) (Year)
8. AGE: Years about 83. Months ? Days ? If less than one day hr. min.
9. Birthplace Unknown (City, town, or county) Ireland (State or foreign country)
10. Usual occupation Laborer
11. Industry or business Laborer

FATHER
12. Name unknown
13. Birthplace Unknown (City, town, or county) Ireland (State or foreign country)

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

16. (a) Informant Comptrollers Office
(b) Address City Hall St. Louis Mo
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 3/24/47 (Month) (Day) (Year)
(c) Place: burial or cremation Kirksville, Mo.
18. (a) Signature of funeral director Keator Burman
(b) Address St. Joseph, Mo.
19. (a) 3-25-47 (Date received local registrar) (b) E. B. Jenkins (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 24 year 1947 hour 7 minute 30 A.M.
21. I hereby certify that I attended the deceased from March 1, 1947, to March 24, 1947; that I last saw him alive on March 22, 1947; and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis — Duration
Due to Generalized arteriosclerosis
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 Forest Thomas (M. D.)
Address St. Joseph Mo Date signed 3/24

(Licensed Embalmer's Statement on Reverse Side) c/o State Hospital no 2

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 Earl C. Ralph

Licensed Embalmer No. 3458

P. O. Address St. Joseph, 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.