S. No. 2
—1/47
5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED APR 7 1948
Registration District No. 314

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 10031

State File No. 10516
Registrar's No. 3034

1. PLACE OF DEATH:

(a) County
(b) City or town St Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution St. Ann's Home
(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 Mo. (b) County 200
(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No. 5301 Page 9
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Winifred A. Murnane
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 Single
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Aug (Month) 3 (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
About	80			hr. min.

9. Birthplace (City, town, or county) England 4 (State or foreign country)
10. Usual occupation Nil
11. Industry or business
FATHER
12. Name Thomas Murnane
13. Birthplace (City, town, or county) England (State or foreign country)
MOTHER
14. Maiden name Julia U.K.
15. Birthplace (City, town, or county) England 4 (State or foreign country)
16. (a) Informant Joseph Rogan
(b) Address 4873 Page
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-30-1948 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary
18. (a) Signature of funeral director Cullen Kelly
(b) Address 4386 Lindell
19. (a) MAR 29 1948 (Date received local registrar) (b) J. F. Bradley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 27 year 1948 hour 4 minute P M.

21. I hereby certify that I attended the deceased from Jan, 1936 to Mar 27, 1948 that I last saw her alive on Mar 24, 1948 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Arteriosclerosis Senile dementia
Due to Senility
Due to —
Other conditions None
(Include pregnancy within 3 months of death)
Major findings: Of operations No
Of autopsy No

Duration

PHYSICIAN
Underline the cause of 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 Dr. Wm. J. Langan Jr. (M. D. or other)
Address 5803 Plymouth Av Date signed Mar 29/48

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

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 James H. Lammers

Licensed Embalmer No. 4142

P. O. Address St. Louis

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.

S. No. 2B
1—3-45
P1X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Agent

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 2034

1. PLACE OF DEATH:

(a) County
(b) City or town St Louis
(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 (b) County
(c) City or town (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Winifred A. Murnane
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 S
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Aug 3 (Month) (Day) (Year)

8. AGE: Years 80 Months Days If less than one day hr. min.

9. Birthplace (City, town, or county) England (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) J. F. Bredeck (Registrar's signature) APR 2 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May Day 27 year 1944 hour minute P. M.
21. I hereby certify that I attended the deceased from 19 to 19; that I last saw h alive on 19; and that death occurred on the date and hour stated above.

Immediate cause of death — Duration

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 (M. D. or other)
Address Date signed

SUPPLEMENTARY

S-1051 b