

FILED JAN 15 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

40244

State File No. \_\_\_\_\_

5369

|   |   |   |   |   |   |  |                |
|---|---|---|---|---|---|--|----------------|
| BIRTH NO. _____   |   | REG. DIST. NO. <u>149</u>   |   | PRIMARY REG. DIST. NO. <u>1002</u>  |   | Registrar's No. <u>5369</u>  |                |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Jackson</u>   |   |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u> |   |  |                |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>   |   | c. LENGTH OF STAY (In this place) <u>50 yrs.</u>                            |   | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>   |   |  |                |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Trinity Lutheran Hosp.</u>   |   |   |   | d. STREET ADDRESS (If rural, give location) <u>3006 Spruce</u>  |   |  |                |
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) <u>Charles</u> b. (Middle) <u>G.</u> c. (Last) <u>McMurray</u>  |   |   | 4. DATE OF DEATH (Month) (Day) (Year) <u>12/30/48</u>   |   |   |  |                |
| 5. SEX <u>Male</u>  | 6. COLOR OR RACE <u>White</u>   | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never Married</u> | 8. DATE OF BIRTH <u>Aug. 12, 1865</u>                   |   | 9. AGE (In years last birthday) <u>83</u>         | Months <u>4</u>  | Days <u>18</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Railroad Fireman</u>   | 10b. KIND OF BUSINESS OR INDUSTRY <u>Terminal R.R.</u>  |   | 11. BIRTHPLACE (State or foreign country) <u>Penn.</u>  |   | 12. CITIZEN OF WHAT COUNTRY? <u>None - U.S.A.</u> |  |                |
| 13a. FATHER'S NAME <u>Samuel McMurray</u>   |   | 13b. MOTHER'S MAIDEN NAME <u>Emeline Reichel</u>                            |   | 14. NAME OF HUSBAND OR WIFE <u>None</u>   |   |  |                |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>   | 16. SOCIAL SECURITY NO. <u>703-03-9039</u>  | 17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Audry Robertson</u>               |   |   | ADDRESS <u>3006 Spruce</u>                        |  |                |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.                     | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>mastoiditis, acute &amp; chronic</u><br><br>ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <u>ulcerated carcinoma of the ear</u><br><br>DUE TO (c) _____<br><br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. <u>Healed carcinoma of the hip.</u> |   |   |   |   | INTERVAL BETWEEN ONSET AND DEATH   |                |
| 19a. DATE OF OPERATION  | 19b. MAJOR FINDINGS OF OPERATION <u>53</u>  |   |   |   |   | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify)  | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |   | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)         |   |   |  |                |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)   | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21f. HOW DID INJURY OCCUR?                              |   |   |  |                |
| 22. I hereby certify that I attended the deceased from <u>Pathology Dept.</u> , to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above. <u>11</u> |   |   |   |   |   |  |                |
| 23a. SIGNATURE (Degree or title) <u>Jack H. Hill M.D.</u>   |   |   | 23b. ADDRESS <u>Trinity Lutheran Hospital</u>           |   |   | 23c. DATE SIGNED <u>31 Dec '48</u>   |                |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   | 24b. DATE <u>1/3/49</u>   | 24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Washington Cem.</u>               |   | 24d. LOCATION (City, town, or county) (State) <u>Kansas City Mo.</u>  |   |  |                |
| DATE REC'D BY LOCAL REG. <u>12-31-48</u>  | REGISTRAR'S SIGNATURE <u>Geraldine Holmes</u>   |   | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Earp &amp; Sons</u> |   | ADDRESS <u>4139 East 15th St.</u>                 |  |                |

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300  
10. 48

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.....

*William H. Eary*

Student Embalmer No. *241*

working under my personal supervision.

Student *William H. Eary*

Student Embalmer

Signed

*John B. Eary*  
*2455-*  
*A.C. 570*

Licensed Embalmer No.

P. O. Address

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.