

FILED AUG 5 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **25147**
Registrar's No. **6610**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY ATW	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Dr. Louis No		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Dr. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION City Hosp #10		d. STREET ADDRESS (If rural, give location) St = 1903 N. Fair	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
Oscar Murray			July 4 1949		

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH Apr 18 1887	9. AGE (If years, give months and days)	
10a. USUAL OCCUPATION (Or kind of work done during most of working life, or if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Ret		Ret		Mo.	

13a. FATHER'S NAME W. K.	13b. MOTHER'S MARYEN NAME W. K.	14. NAME OF HUSBAND OR WIFE W. K.
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give branch and date of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS
Ret	W. K.	T. K. Taylor 500 Clark

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES		
	MORBID CONDITIONS, if any, giving rise to the above cause (a) stating the underlying cause last.		
	DUE TO (b)		
	DUE TO (c)		
	II. OTHER SIGNIFICANT CONDITIONS		
	Conditions contributing to the death but not related to the disease or condition causing death.		

Sardural Hemorrhage
Line, Fall, Cause and Manner of Same Could Not Be Determined

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
	Open Verdict	

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)
		830

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?
		321X

22. I hereby certify that I attended the deceased from _____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at **3:08** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Robert T. Linn, Deputy Coroner	1300 Clark	7/5/49

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
	JUL 31 1949	Anatomical Board	

DATE REC'D BY LOCAL REG. JUL 31 1949	REGISTRAR'S SIGNATURE J. B. Laster	25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS Rowland Mortuary Service Inc.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

607 29 258

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed Ralph W. Henson

Signed.....
Student Embalmer

Licensed Embalmer No. 2791

P. O. Address St. Louis, 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.