

FILED SEP 28 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

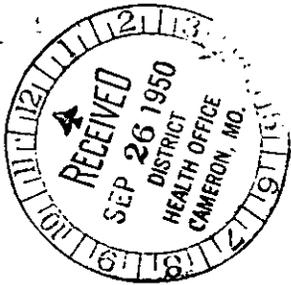
State File No. 32466

BIRTH NO. _____		REG. DIST. NO. <u>374</u>		PRIMARY REG. DIST. NO. <u>6276</u>		Registrar's No. <u>45</u>	
1. PLACE OF DEATH a. COUNTY <u>Worth</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Worth</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural-West Union Township</u>		c. LENGTH OF STAY (in this place) <u>23 years</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural-West Union Township</u> <u>1130</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				d. STREET ADDRESS (If rural, give township) <u>Sheridan</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>William</u> b. (Middle) <u>Douglass</u> c. (Last) <u>Murray</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>9-19-1950</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>1-1-1861</u>	
9. AGE (In years last birthday) <u>89</u>		10. MONTHS <u>8</u>		11. DAYS <u>18</u>		IF UNDER 1 YEAR OF AGE: Hours <u>18</u> Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>farming</u>		11. BIRTHPLACE (State or foreign country) <u>Knox County, Iowa</u> <u>1</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>Stephen Murray</u>			13b. MOTHER'S MAIDEN NAME <u>Nancy Jane Cabbage</u>		14. NAME OF HUSBAND OR WIFE _____		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Verne Wake Sheridan, Mo.</u> ADDRESS _____			
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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Arteriosclerosis Cardiovascular Disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u> 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. <u>4221</u>					
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____					
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) (Minute) _____		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>June</u> , 19 <u>50</u> , to <u>Sept</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>10 Sept</u> , 19 <u>50</u> , and that death occurred at <u>10:45 A. m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Frank B. Matsumoto M.D.</u>			23b. ADDRESS <u>Grant City Mo.</u>		23c. DATE SIGNED <u>9/20/50</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		24b. DATE <u>9-21-1950</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Plattville Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Plattville, Iowa</u>	
DATE REC'D BY LOCAL REG. <u>9-21-1950</u>		REGISTRAR'S SIGNATURE <u>Walter E. Dawson</u> <u>345</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Arch C. Duffer</u> ADDRESS <u>Grant City, Mo.</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

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**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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed Arch C. Dunfee

Licensed Embalmer No. 3252

P. O. Address Grant City, 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.