

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **8498**

1326

No. 300

10-48

FILED MAR 29 1952

BIRTH NO.

REG. DIST. NO. **149**

PRIMARY REG. DIST. NO. **1002**

Registrar's No.

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) Kansas City	
d. FULL NAME OF HOSPITAL OR INSTITUTION General Hospital No. 1		d. STREET ADDRESS (If rural, give location) 816 W. 40th STREET	

3. NAME OF DECEASED (Type or Print) a. (First) LEE	b. (Middle) R.	c. (Last) Murchison	4. DATE OF DEATH (Month) (Day) (Year) 3 19 52
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5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH APRIL 24, 1888	9. AGE (In years last birthday) 63	IF UNDER 1 YEAR Months	IF UNDER 4 HRS. Hours	IF UNDER 15 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN	10b. KIND OF BUSINESS OR INDUSTRY TRAVELING	11. BIRTHPLACE (State or foreign country) SAN MARCUS, TEXAS	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME MORGAN MURCHISON	13b. MOTHER'S MAIDEN NAME UNKNOWN	14. NAME OF HUSBAND OR WIFE FAY MURCHISON
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME FAY MURCHISON	ADDRESS KANSAS CITY, MO.
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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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of kidney with metastases to liver, lungs, kidney and chestwall		
	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.		180X	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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) m.	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 **Mar. 3, 1952**, to **Mar. 19, 1952**, that I last saw the deceased alive on **Mar. 19, 1952** and that death occurred at **9:50A m.**, from the causes and on the date stated above.

23a. SIGNATURE B.I. Burns (degree or title)	23b. ADDRESS 24th & Cherry	23c. DATE SIGNED 3-20-52
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 3-22-1952	24c. NAME OF CEMETERY OR CREMATORY MT. WASHINGTON	24d. LOCATION (City, town, or county) (State) KANSAS CITY, MO.
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DATE REC'D BY LOCAL REG. 3-21-52	REGISTRAR'S SIGNATURE Sheralding Holmes	25. FUNERAL DIRECTOR'S SIGNATURE Geo. C. Carson	ADDRESS Independence, Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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

Dr. Pappas

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 *Tom D. Marbland*

Signed.....
Student Embalmer

Licensed Embalmer No. *4592*

P. O. Address *Indep 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.