

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

22429

State File No.

FILED JUL 2 - 1952

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **5767**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS MO		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS 204.9	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location) 6531 MITCHELL	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. JOHN'S HOSPITAL 4			

3. NAME OF DECEASED (Type or Print) a. (First) MILLIE b. (Middle) - c. (Last) MURRAY			4. DATE OF DEATH (Month) (Day) (Year) JUNE 18 1952		
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5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED		8. DATE OF BIRTH MAR. 26 1901		9. AGE (In years last birthday) 51 IF UNDER 1 YEAR Months Days IF UNDER 1 HR. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEAMSTRESS				10b. KIND OF BUSINESS OR INDUSTRY LANG KOHN		11. BIRTHPLACE (City and State or Foreign Country) ARKANSAS		12. CITIZEN OF WHAT COUNTRY?	

13a. FATHER'S NAME GERDON SMITH		13b. MOTHER'S MAIDEN NAME - WILLIAMS		14. NAME OF HUSBAND OR WIFE EDWARD C. MURRAY	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS EDWARD C. MURRAY 6531 MITCHELL	
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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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage			INTERVAL BETWEEN ONSET AND DEATH 3 hrs
		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.			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input 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)	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 331X	
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22. I hereby certify that I attended the deceased from June 18, 1952 to _____, 19____, that I last saw the deceased alive on June 18, 1952, and that death occurred at 10:55 P.M., from the causes and on the date stated above.

23a. SIGNATURE William D. Turner M.D. (Degree or title)		23b. ADDRESS 16 Hampton Place, St. Louis		23c. DATE SIGNED June 20 1952	
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24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		24b. DATE JUNE 21 1952		24c. NAME OF CEMETERY OR CREMATORY VAL HALLA CEM.		24d. LOCATION (City, town, or county) (State) ST. LOUIS MO	
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DATE REC'D BY LOCAL HEALTH DEPT. JUN 20 1952		REGISTRAR'S SIGNATURE J. Carl Smith MD		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Thomas Kutis 2906 Gravois	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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

Reg. Budde

Licensed Embalmer No.

3989

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.