.S. No.300
ev. 10.48

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

FILED AUG 15 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 28197

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 3407

1. PLACE OF DEATH
a. COUNTY: Jackson
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kansas City
c. LENGTH OF STAY (In this place): 2 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): K.C. Tuberculosis Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Jackson
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kansas City
d. STREET ADDRESS (If rural, give location): 1733 Hardland

3. NAME OF DECEASED (Type or Print)
a. (First): Sam
b. (Middle): Murray
c. (Last):

4. DATE OF DEATH (Month) (Day) (Year): 7-29-1952

5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Sing.
8. DATE OF BIRTH: 7-1-1899
9. AGE (In years last birthday): 53
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none.
10b. KIND OF BUSINESS OR INDUSTRY: laborer.
11. BIRTHPLACE (State or foreign country): Cedar City Missouri
12. CITIZEN OF WHAT COUNTRY?: U.S.

13a. FATHER'S NAME: Jim Murray
13b. MOTHER'S MAIDEN NAME: Frances Pepper
14. NAME OF HUSBAND OR WIFE: —

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
If yes, give war or dates of service:
16. SOCIAL SECURITY NO.: —
17. INFORMANT'S SIGNATURE OR NAME: Dear Mae Cooper
ADDRESS: 2522 Garfield

18. CAUSE OF DEATH — MEDICAL CERTIFICATION

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.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Pulmonary Tuberculosis — 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.

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19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

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 ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 6-12-, 1950, *to* 7-29-, 1952, *that I last saw the deceased alive on* 7-29-, 1952, *and that death occurred at* 12:45 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE Edward P. Altomare (Degree or title): Edward P. Altomare M.D.
23b. ADDRESS: K.C.T.B. Hospital
23c. DATE SIGNED: 7-29-52

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: 7-31-52
24c. NAME OF CEMETERY OR CREMATORY: Slater City Cem.
24d. LOCATION (City, town, or county) (State): Slater, Mo.

DATE REC'D BY LOCAL REG.: 7-29-52
REGISTRAR'S SIGNATURE: Geraldine Holmes
FUNERAL DIRECTOR'S SIGNATURE: Hill Bros.
ADDRESS: Slater, Mo.

(Licensed Embalmer's Statement on Reverse Side)

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.....

Signed.....
Student Embalmer

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.