

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

9525

State File No.

FILED MAR 16 1953

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 5467 Registrar's No. 248

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Greene	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural 2nd Robberson		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural 2nd. Robberson	
d. FULL NAME OF HOSPITAL OR INSTITUTION Rt. 5 Springfield		d. STREET ADDRESS (If rural, give location) Rt. 5 Springfield 0390 0	
3. NAME OF DECEASED (Type or Print) a. (First) ROBBIE b. (Middle) D. c. (Last) MURRAY		4. DATE OF DEATH (Month) (Day) (Year) March 9, 1953	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Aug. 15, 1898
9. AGE (In years last birthday) 61		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (State or foreign country) Greene Co. Missouri U
13a. FATHER'S NAME H.L. Fallin		13b. MOTHER'S MAIDEN NAME Rachel Jones	
14. NAME OF HUSBAND OR WIFE Walter Murray		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No	
17. INFORMANT'S SIGNATURE OR NAME Walter Murray		ADDRESS Rt. 5 Springfield Mo	
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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension, mild. DUE TO (c) arteriosclerosis, II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION none		19b. MAJOR FINDINGS OF OPERATION 4201	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
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) (Min)		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 5 March, 1953 , to 9 Mar , 1953, that I last saw the deceased alive on 9 Mar , 1953, and that death occurred at 7:05A m. , from the causes and on the date stated above.			
23a. SIGNATURE Hans G. Kuah (Degree or title) MD		23b. ADDRESS 1630 N. Jefferson Springfield 2. Mo.	
23c. DATE SIGNED 9 Mar '53			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 3-11-53	
24c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery		24d. LOCATION (City, town, or county) (State) Springfield Missouri	
DATE REC'D BY LOCAL REG. 3-12-53		REGISTRAR'S SIGNATURE Edith Wilkerson Regent	
25. FUNERAL DIRECTOR'S SIGNATURE J.W. Klingner & Co.		ADDRESS Springfield Mo.	

(Licensed Embalmer's Statement on Reverse Side)

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

390
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S. No. 300
V. 10.48

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 _____

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.