

no. 300
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FILED AUG 29 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

25384

State File No.

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 907

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>St. Joseph</u>	c. LENGTH OF STAY (in this place) <u>15 years</u>	c. CITY OR TOWN <u>St. Joseph</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>821 N. 2nd St.</u>		STREET ADDRESS (If rural, give location) <u>821 N. 2nd St.</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Linnie</u> b. (Middle) <u>Mae</u> c. (Last) <u>Murray</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>August 17, 1955</u>		
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>November 21, 1894</u>	9. AGE (In years last birthday) <u>60</u>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Wallace, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>

13a. FATHER'S NAME <u>John Norris</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah Estes</u>		14. NAME OF HUSBAND OR WIFE <u>Earl Henry</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Earl Murray, 821 N. 2nd, St. Joseph, Mo.</u>	

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 <u>30 MIN.</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>CORONARY OCCLUSION</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>CORONARY INSUFFICIENCY</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		DUE TO (c) _____	

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>4201.</u>		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 APRIL 10, 1954, to AUG. 17, 1955, that I last saw the deceased alive on AUG. 17, 1955, and that death occurred at 8:00 a. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>[Signature]</u>		23b. ADDRESS <u>1302 FARM ST. JOSEPH, MO.</u>		23c. DATE SIGNED <u>8-18-55</u>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>8/19/1955</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Turner Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Buchanan County, Mo.</u>	
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DATE REC'D BY LOCAL REG. <u>Aug 24, 1955</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>St Joseph Mo.</u>	
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(Licensed Embalmer's Statement on Reverse Side)

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.....
Signature of Student Embalmer

Signed.....
Philip D. Collins

Licensed Embalmer No. *4957*
P. O. Address *319 - So. 10th St. W. Pa.*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.