

FILED DEC 5 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **36355**

BIRTH NO. _____ REG. DIST. NO. **82** PRIMARY REG. DIST. NO. **3017** Registrar's No. **124**

1. PLACE OF DEATH a. COUNTY Cooper		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Caldwell	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Boonville	c. LENGTH OF STAY (In this place) 2 WKS	c. CITY OR TOWN Cowgill	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph's Hospital		e. STREET ADDRESS (If rural, give location) 01501	

3. NAME OF DECEASED (Type or Print) Mattie Murray	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) Nov. 26, 1955
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5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH May 31-1897	9. AGE (In years last birthday) 68	IF UNDER 1 YEAR Months	IF UNDER 1 HOUR Hours	IF UNDER 1 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	10b. KIND OF BUSINESS OR INDUSTRY home	11. BIRTHPLACE (City and State or Foreign Country) Cowgill, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Isac Jackson	13b. MOTHER'S MAIDEN NAME Mary Ann Chesier	14. NAME OF HUSBAND OR WIFE Virgil T 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) no	16. SOCIAL SECURITY NO. unknown	17. INFORMANT'S SIGNATURE OR NAME William Murray	ADDRESS Kingston, 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, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Edema - Bilateral		INTERVAL BETWEEN ONSET AND DEATH 2 days	
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Traumatic Cerebral Hemorrhage			12 days Origin
	DUE TO (c) Automobile Accident			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Multiple Fractures Cervis, Multiple Fracture Ribs, Ribs, Fracture Clavicle, Right, Diabetes Mellitus				

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE Automobile Accident	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) State Highway	21c. (CITY, TOWN, OR TOWNSHIP) Cooper (COUNTY) Mo. (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Nov. 13 1955 A.M.	21e. INJURY OCCURRED WHILE AT WORK? <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? Auto Accident
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22. I hereby certify that I attended the deceased from **Nov. 13, 1955**, to **Nov. 26, 1955**, that I last saw the deceased alive on **Nov. 26, 1955**, and that death occurred at **1:00 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) E. T. Humphreys M.D.	23b. ADDRESS Boonville Mo.	23c. DATE SIGNED Nov. 26, 1955
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24a. BURIAL, CREMATION, REMOVAL (Specify) burial	24b. DATE 11/28/55	24c. NAME OF CEMETERY OR CREMATORY Kingston Cemetery	24d. LOCATION (City, town, or county) (State) Kingston, Mo.
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DATE REC'D BY LOCAL REG. 11/26/55	REGISTRAR'S SIGNATURE De Hooper 381-0	25. FUNERAL DIRECTOR'S SIGNATURE B. W. Shaker	ADDRESS Boonville Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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

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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 *Berry W. Shacker*

Licensed Embalmer No. *394*

P. O. Address *Conville*

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.