

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-016227
STATE FILE NUMBER
3560

FILED APR 18 1958

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 3560

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-57

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, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION City Hospital #1		d. STREET ADDRESS (If outside, give location) 1523 N. Taylor Ave	
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM (Will) MURRAY		4. DATE OF DEATH Month Day Year March 26 1958	
5. SEX Male	6. COLOR OR RACE Col	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 30, 1896
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Tire Co.	11. BIRTHPLACE (City and state or country) Forrest City, Ark
13a. FATHER'S NAME Charlie Murray		13b. MOTHER'S MAIDEN NAME Elsie ?	14. NAME OF HUSBAND OR WIFE Ruby Murray
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes WW # 1		16. SOCIAL SECURITY NO. 489-05-5748	17. INFORMANT Address Ruby Murray 1523 N. Taylor Ave.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Fracture of Skull;</i> DUE TO (b) <i>Subdural Hemorrhage</i> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Suffered when struck by</i>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
20c. TIME OF INJURY Hour Month, Day, Year 9:10 a.m. 3 26 58		18b. PLACE AND HOW INJURY OCCURRED. (Enter on line of injury in PART I or PART II of item 18.) <i>while working at 410 South Chessa, about 9:10 am</i>	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>18 Garage</i>	
20f. CITY, TOWN OR LOCATION St. Louis		COUNTY STATE Mo 000	
21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>Joseph M. Quinn M.D.</i>		22b. ADDRESS 1300 Clark Ave	
22c. DATE SIGNED 3/28/58			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE April 1, 1958	
23c. NAME OF CEMETERY OR CREMATORY National		23d. LOCATION (City, town, or county) (State) Jefferson Brks Mo	
24. FUNERAL DIRECTOR J.H. Randle & Son 3133 Bell Ave		25. DATE RECD. BY LOCAL REG. MAR 28 '58	
26. REGISTRAR'S SIGNATURE <i>Carl Smith Mo</i>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

8961 92 719

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 *Ethel A. Harris*

Licensed Embalmer No. *445*
P. O. Address *4181 Wash*

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.