

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-005189
STATE FILE NUMBER

FILED MAR 9 1959 Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 221

300
1-57

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield		c. CITY OR TOWN St. Louis	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF HOSPITAL OR INSTITUTION Medical Center for Federal Prisoners		d. STREET ADDRESS (If outside, give location) 3711 N. 25th Street	
Length of stay in 1b 3 days		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Theodore Middle - Last Murdock			4. DATE OF DEATH Month February Day 28 Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> 3 DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH October 10, 1908
9. AGE (In years birthday) 50		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist	11. BIRTHPLACE (City and state or country) Sikeston, Missouri
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME David Murdock (deceased)	
13b. MOTHER'S MAIDEN NAME Katherine Cline Murdock (dec.)		14. NAME OF HUSBAND OR WIFE Divorced	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Files-MCFP		Address Springfield, Missouri	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema and atelectasis of lungs			INTERVAL BETWEEN ONSET AND DEATH 20 hours
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Malignancy, metastatic, in lung and liver			2-3 months
DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? 1992 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) -----	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.		-----	
20d. INJURY OCCURRED WHILE AT <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.) -----	
20f. CITY, TOWN, OR LOCATION -----		COUNTY _____ STATE _____	
21. I attended the deceased from The Medical Staff 2-25-59 to 2-28-59 and last saw him alive on February 28, 1959 Death occurred at 12:28 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>J.A. Hunter M.D.</i>		22b. ADDRESS Medical Center for Federal Prisoners, Springfield, Mo.	
22c. DATE SIGNED 2-28-59			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE Mar. 2, 1959	
23c. NAME OF CEMETERY OR CREMATORY Unknown		23d. LOCATION (City, town, or county) (State) St. Louis, Missouri	
24. FUNERAL DIRECTOR AYRE-GOODWIN: Springfield, Mo.		25. DATE RECD. BY LOCAL REG. 2-2-59	
26. REGISTRAR'S SIGNATURE <i>Effie G. Melton</i>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

vector, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 *Robert M. Jones*

Licensed Embalmer No. *4732*
P. O. Address *Springfield*

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.