

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011746
STATE FILE NUMBER

FILED MAR 30 1959

Registration District No. 317 Primary Registration District 548 Registrar's No. 741

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1-57

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|---|------------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY St. Louis | | 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 Webster Groves | | c. CITY OR TOWN Webster Groves | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 243 E. Kirkham | | d. STREET ADDRESS (If outside, give location) 243 E. Kirkham | |
| 3. NAME OF DECEASED (Type or print) First M A R Y Middle M C Last M U R R Y | | 4. DATE OF DEATH Month 3 Day 18 Year 1959 | |
| 5. SEX Female | 6. COLOR OR RACE 3 Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12/21/1875 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10b. KIND OF BUSINESS OR INDUSTRY None | 11. BIRTHPLACE (City and state or country) Solitude, Indiana |
| 13a. FATHER'S NAME William Brown | | 13b. MOTHER'S MAIDEN NAME Unknown | 12. CITIZEN OF WHAT COUNTRY? U. S. A. |
| 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. unk. | 14. NAME OF HUSBAND OR WIFE Granville McMurry |
| 17. INFORMANT Mrs. Rowena Reynolds | | | Address 243 E. Kirkham |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Senility | | | INTERVAL BETWEEN ONSET AND DEATH 3 yrs. |
| 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. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 20f. CITY, TOWN, OR LOCATION COUNTY STATE | |
| 21. I attended the deceased from Death occurred at 30 Jan 1956 to March 1959 and last saw her alive on 3/18/59 m on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE <i>[Signature]</i> | | 22b. ADDRESS 243 E. Kirkham Webster Groves Mo. | |
| 22c. DATE SIGNED 3-19-59 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 23b. DATE 3/19/1959 | |
| 23c. NAME OF CEMETERY OR CREMATORY LOCAL | | 23d. LOCATION (City, town, or county) (State) Carmi, Illinois | |
| 24. FUNERAL DIRECTOR Charles J. Gates | | 25. DATE RECD. BY LOCAL REG. 3-19-59 | |
| 26. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, 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 *Geoffrey Swan*
Licensed Embalmer No. 4580

P. O. Address 4107 Finney

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.