

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-015476

State File No.

BIRTH NO. **MAY 1 1959**

REG. DIST. NO.

PRIMARY REG. DIST. NO.

Registrar's No. **2 3686**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived; if institution: residence before admission)	
b. CITY (If outside corporate limits, write RURAL, and give township) St. Louis		c. CITY OR TOWN St. Louis	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 St. John Hospital		e. STREET ADDRESS (If rural, give location) 7311 a S. Broadway	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) Debrah	b. (Middle) Kay	c. (Last) Murray	(Month) April	(Day) 14	(Year) 1959
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married	8. DATE OF BIRTH Feb. 22, 1959	9. AGE (In years last birthday) 1	IF UNDER 1 YEAR: MONTHS 22
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nil		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY? U S A	

13a. FATHER'S NAME Charles Murray	13b. MOTHER'S MAIDEN NAME Louise Tucker	14. NAME OF HUSBAND OR WIFE Charles Murray
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Charles Murray
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, asthma, etc. It means the disease, injury, or complication which caused death.		19. ADDRESS 7311 a S. Broadway

18. CAUSE OF DEATH		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cystic Hygroma of Neck & Antecedent Causes		DUE TO (b) invasion of adjacent tissues		
DUE TO (c) 228X		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
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 **FEB 22**, 19**59**, to **Feb 22**, 19**59**, that I last saw the deceased alive on **Feb 22**, 19**59**, and that death occurred at **7:30 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE John S. Leafy (Degree or title) M.D.	23b. ADDRESS 950 Francis Pl.	23c. DATE SIGNED 4-14-59
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE April 14, 1959	24c. NAME OF CEMETERY OR CREMATORY Naylor, Missouri
24d. LOCATION (City, town, or county) Naylor, Missouri		(State)

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE APR 14 59	REGISTRAR'S SIGNATURE Earl Smith, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE C. Hoffmeister Mortuaries	ADDRESS 7814 S. Broadway
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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 *Levin C. Hoffmeister*.....

Licensed Embalmer No... *387*

P. O. Address *2814 S. Park*

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.