

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-022571

FILED JUL 7 1959 311

Registration District No. _____ Primary Registration District No. 4456 Registrar's No. 23

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>ST CLAIR</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>CECILIA</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Ripletton City</u>		Length of stay in 1b <u>1 day</u>	c. CITY OR TOWN <u>ELDERADO SPRING</u> ^{Inside Limits} Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ELLETT, M. Hosp.</u>		Inside limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) _____ Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>TERESA</u> Middle <u>MARIE</u> Last <u>MURRAY</u>			4. DATE OF DEATH Month <u>JULY</u> Day <u>4</u> Year <u>1959</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>6-30-57</u>	9. AGE (last birthday) <u>1</u>	IF UNDER 1 YEAR IF UNDER 24 HR Months _____ Days <u>5</u> Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and state or country) <u>Ripletton City Mo.</u>	
12. CITIZEN OF WHAT COUNTRY <u>USA</u>					

13a. FATHER'S NAME <u>EDWIN MURRAY</u>		13b. MOTHER'S MAIDEN NAME <u>BERNARDINE STROPE</u>		14. NAME OF HUSBAND OR WIFE _____	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT <u>EDWIN MURRAY</u> Address <u>ELDERADO SP.</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY HEMORRHAGE</u> ^{CAUSE} <u>UNKNOWN</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____		
	DUE TO (c) _____		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
---	--	--	--

19. WAS AUTOPSY PERFORMED? 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 _____ p.m. _____	Month, Day, Year _____		
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.) _____	20f. CITY, TOWN, OR LOCATION _____	COUNTY _____ STATE _____

21. I attended the deceased from June 30 1959 to July 4 1959 and last saw her ^{her} _{him} alive on July 4 1959
Death occurred at 1:40 P on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Robert H. Bronsberger MD</u>		22b. ADDRESS <u>Ripletton City, Mo.</u>		22c. DATE SIGNED <u>July 4 1959</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>July 5-59</u>	23c. NAME OF CEMETERY OR CREMATION <u>ST. MARYS</u>		23d. LOCATION (City, town, or county) (State) <u>MOUSTROSE, Mo.</u>
24. FUNERAL DIRECTOR <u>Osca Eckhoff</u>		ADDRESS <u>Ripletton City</u>	25. DATE RECD. BY LOCAL REG. <u>7-3-59</u>	26. REGISTRAR'S SIGNATURE <u>Oleo Abney</u>

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Oscar Eckhoff

Licensed Embalmer No. 39

P. O. Address Oppland

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure 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.