

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-013006

FILED VS MAR 25 1960

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 3003** STATE FILE NUMBER

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		Length of stay in 1b Life		c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Incarinate Word			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1548 S. Compton			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Kent Middle Randall Last Murray			4. DATE OF DEATH Month March Day 13 Year 1960				
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 2/15/60	9. AGE (last birthday) --	IF UNDER 1 YEAR Months -- Days 28	IF UNDER 24 HR Hours -- Min. --
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) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Otto Murray			13b. MOTHER'S MAIDEN NAME Margie Phelps		14. NAME OF HUSBAND OR WIFE None		
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. None	17. INFORMANT Address Otto Murray, 1548 S. Compton				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia and new, also DUE TO (b) Right Pleural adhesion DUE TO (c) Right Pleural adhesion Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH approx 10 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 7 months before now about 1 month old also had tuberculosis since birth						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.) 763.0			
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.		Month, Day, Year					
20d. INJURY OCCURRED 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 2-15-60 to 3-13-60 and last saw her alive on 3-13-60 Death occurred at Incarinate Word Hosp on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) John T Flynn BSMID				22b. ADDRESS 1715 So 39th St Louis Mo		22c. DATE SIGNED 3-14-60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 3/15/60	23c. NAME OF CEMETERY OR CREMATORY St. Trinity		23d. LOCATION (City, town, or county) St. Louis Co., Mo		(State)
24. FUNERAL DIRECTOR McLaughlin, 2301 Lafayette (4)				25. DATE RECD. BY LOCAL REG. MAR 15 1960	26. REGISTRAR'S SIGNATURE Earl Smith M.D. <i>M. J. 13.</i>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Dr Flynn
1715 S. 39

STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

Signed *A. G. Farris*

Licensed Embalmer No. *3384*
P. O. Address *A. Farris*

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