

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-000767

FILED VS JAN 26 1961 098

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. 19

AMENDED  
 DATE AMENDED  
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 SHOULD READ  
 BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>Daviess</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Daviess</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Rural Union Twp.</b>			Length of stay in lb <b>10 Yrs.</b>		c. CITY OR TOWN <b>Rural Union Twp.</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>4 Mi. East Gallatin</b>				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>4 Mi. East Gallatin</b>		
3. NAME OF DECEASED (Type or print) First <b>Agnes</b>		Middle <b>May</b>		Last <b>Murry</b>		4. DATE OF DEATH Month <b>January</b> Day <b>8</b> Year <b>1961</b>		
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>1-14-1899</b>		
9. AGE (last birthday) <b>61</b>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HR Hours _____ Min. _____				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (City and state or country) <b>Gallatin, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Warren Manuel</b>			13b. MOTHER'S MAIDEN NAME <b>Sarah McCoy</b>			14. NAME OF HUSBAND OR WIFE <b>Oscar Murry (Dec'd)</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>----</b>		17. INFORMANT Address <b>Mrs. Shirley Miller, Jameson, Mo.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>30 min.</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Hypertension &amp; Cardiac enlargement</b> DUE TO (c) <b>arteriosclerosis, Edema of chest</b>							<b>2 yr</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Malaise of uterus, heart blood at times</b>							<b>1 yr.</b>	
19. WAS AUTOPSY PERFORMED? YES <input 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. _____		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 <b>June 1950</b> to <b>Jan 8</b> and last saw her/him alive on <b>Jan 8</b> Death occurred at <b>6A</b> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <b>H. Bailey D.D.</b>				22b. ADDRESS <b>Gallatin Mo</b>		22c. DATE SIGNED <b>1-14-61</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>1-13-1961</b>		23c. NAME OF CEMETERY OR CREMATION <b>Centenary Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Gallatin, Mo.</b>		
24. FUNERAL DIRECTOR <b>H.C. Richardson</b> ADDRESS <b>Hope funeral home, Gallatin, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>Jan. 16, 1961</b>		26. REGISTRAR'S SIGNATURE <b>Vergie M. Kuyperhart</b>		

**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 L. O. Erickson

Licensed Embalmer No. 3302

P. O. Address Fall River, N. H.

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.