

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 3189 STATE FILE NUMBER

FILED APR 14 1961

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| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. Institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>St. Louis</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u> | | Length of stay in 1b <u>2 weeks</u> | c. CITY OR TOWN <u>Berkeley</u> <u>St. Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. John's Hospital</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>6101 Wulff Dr.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Susan E. Murray</u> | | | 4. DATE OF DEATH Month Day Year <u>April 4, 1961</u> | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>9/20/1877</u> | 9. AGE (last birthday) <u>83</u> | IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | 11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u> | 12. CITIZEN OF WHAT COUNTRY <u>U.S.</u> | |
| 13a. FATHER'S NAME <u>Edward Murray</u> | | 13b. MOTHER'S MAIDEN NAME <u>Ann Finnegan</u> | | 14. NAME OF HUSBAND OR WIFE <u>Joseph B. Murray</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address <u>Alice Bruer 6101 Wuff Dr. Berkeley, Mo.</u> | |

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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <u>Pulmonary Insufficiency</u> | | | <u>unknown</u> |
| DUE TO (b) <u>Pulmonary Emphysema</u> | | | <u>unknown</u> |
| DUE TO (c) <u>502.0</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease/condition given in PART I (a) <u>Acute and Chronic Bronchitis</u> | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |

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| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 Mar 18, 1961 to Apr. 4, 1961 and last saw her/him alive on Apr. 3, 1961
Death occurred at 6:00 A on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE (Degree or title) <u>Andrew J. Fritsch M.D.</u> | 22b. ADDRESS <u>307 S. Euclid</u> | 22c. DATE SIGNED <u>Apr 5, 1961</u> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>4/7/1961</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u> | 23d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u> |
| 24. FUNERAL DIRECTOR ADDRESS <u>Morrell Mortuary 3710 North Grand</u> | | 25. DATE RECD. BY LOCAL REG. <u>APR 5 1961</u> | 26. REGISTRAR'S SIGNATURE <u>Earl Smith M.D.</u> |

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

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

Laron E. Percy

Licensed Embalmer No. 4094

P. O. Address St. Louis,

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.