MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-022964
STATE FILE NUMBER

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6173

FILED JUL 7 1961

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis
Length of stay in 1b: Life
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: De Paul Hospital
Inside Limits: Yes [X] No [ ]

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY
c. CITY OR TOWN: St. Louis
Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 4770 Maffitt Avenue,
Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First: JAMES Middle: P. Last: MURRAY
4. DATE OF DEATH: Month June Day 30th Year 1961
5. SEX: Male
6. COLOR OR RACE: White
7. Married [X] Never Married [ ] Widowed [ ] Divorced [ ]
8. DATE OF BIRTH: 1-5-1889
9. AGE (last birthday): 72
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): Retired Cutter
10b. KIND OF BUSINESS OR INDUSTRY: Monument
11. BIRTHPLACE (City and state or country): St. Louis, Missouri
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME: Thomas Murray
13b. MOTHER'S MAIDEN NAME: Mary Ellen O'Neill
14. NAME OF HUSBAND OR WIFE: Jane Murray
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): World War #1
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address: Mrs. Jane Murray, 4770 Maffitt Avenue,

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): RT Bronchiogenic Carcinoma
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 162.1
INTERVAL BETWEEN ONSET AND DEATH:
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. [ ] Yes [ ] No [ ] Unknown

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]
20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
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 [ ] NOT WHILE AT WORK [ ]
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 6/20/61, to 6/30/61 and last saw her/him alive on 6/29/61
Death occurred at 5:45 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.
22a. SIGNATURE (Degree or title): James C. West MD
22b. ADDRESS: 634 N. Grand St. Lou.
22c. DATE SIGNED: 7/2/61
23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 7-3-61
23c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery
23d. LOCATION (City, town, or county) (State): St. Louis, Missouri.
24. FUNERAL DIRECTOR: CALVIN F. FEUTZ FUNERAL HOME
ADDRESS: 4828 Natural Bridge Blvd., St. Louis, 15, Missouri
25. DATE RECD. BY LOCAL REG.: JUL 3 1961
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO.	SHOULD READ	INSTEAD OF	DATE AMENDED
			6/72

BY AFFIDAVIT OF DOCUMENT

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 John A. Mlinar

Licensed Embalmer No. 4186

P. O. Address St. Louis M

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.