

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

32747
Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No. **791**
 (b) Township..... Primary Registration District No. **1003**
 (c) City **St. Louis**..... (d) Street No. **City Hospital No. 1003** St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Agnes Murray
3307 a Sidney St. **17**
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **female** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Widowed**
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **THOMAS J. MURRAY.**
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **March 7, 1867**
 7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
67 70 6 13
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **hvk at home**
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **9/20/37** 19...
 22. I HEREBY CERTIFY That I attended deceased from **6/16/37** to **9/20/37**, 19...
 I last saw her **alive on 9/20/37**, 19... Death is said to have occurred on the date stated above, at **4 a** m.
 The principal cause of death and related causes of importance were as follows:
Carcinoma of head of pancreas obstructive jaundice
 Date of onset
 Other contributory causes of importance:
Diabetes Mellitus
Tuberculosis of colon

12. BIRTHPLACE (CITY OR TOWN) **Illinois**
 (STATE OR COUNTRY)

13. NAME **Tim Sullivan**

14. BIRTHPLACE (CITY OR TOWN) **IRELAND**
 (STATE OR COUNTRY)

15. MAIDEN NAME **Adelie ? UNKNOWN**

16. BIRTHPLACE (CITY OR TOWN) **Ireland**
 (STATE OR COUNTRY)

17. INFORMANT **Hosp. Info M. Kent 3307.**
 (ADDRESS) **MADALYN KIENSTRA SIDNEY, 57**

18. BURIAL, CREMATION, OR REMOVAL PLACE **CALVERY** DATE **9-22**, 19**37**

19. FUNERAL DIRECTOR **MULLEN BROS.**
 (ADDRESS) **4259 LINDELL BLVD.**

20. **SEP 21 1937** 19... **J. J. Bredeck**
 Local Registrar.

Name of operation..... Date of.....
 What test confirmed diagnosis?..... Was there an autopsy? **Yes**

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide?..... Date of injury....., 19...
 Where did injury occur?..... (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

24. Was disease or injury in any way related to occupation of deceased?.....
 If so, specify.....
 (Signed) **E. P. REH.**, M. D.
 (Address) **City Hospital No. 1**

STATEMENT BY LICENSED EMBALMER

I, H. E. Burgess, Licensed Embalmer No. 3547
hereby certify that the body recorded on the reverse side of this certificate was embalmed by myself
..... L. E.
No. or by Registered Apprentice No.
working under my personal supervision.

Signed H. E. Burgess
Licensed Embalmer No. 3547

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.)