

DEC'D MAR 9 1939

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

5352  
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399  
 (b) Township Jackson Primary Registration District No. 1002 Registered No. 551  
 (c) City Kansas City (d) Street No. 720 Genl Hosp 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

(a) Residence, No. 1707 Bell Ave St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Adah Murrell

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 25 1898

7. AGE YEARS 40 MONTHS 3 DAYS 14 IF LESS than 1 day, ..... hrs. or ..... min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Laborer  
 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

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) mo

FATHER 13. NAME James Murrell

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) mo

MOTHER 15. MAIDEN NAME Crawright

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) mo

17. INFORMANT (ADDRESS) Deena Clark 720 Genl Hosp

18. BURIAL, CREMATION, OR REMOVAL PLACE Highland DATE Feb 11 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Boyd & Henderson

20. FILED 29 1939 M. M. Browne Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-9 1939

22. I HEREBY CERTIFY, That I attended deceased from 12-10 1938, to 2-9 1939

I last saw him alive on 2-9 1939 Death is said to have occurred on the date stated above, at 2:40 a m

The principal cause of death and related causes of importance were as follows:

Subacute Bacterial Endocarditis, multiple abscesses liver, spleen & kidneys  
 Date of onset  
 Other contributory causes of importance:

Pulmonary Edema

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.

Manner of injury .....  
 Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? 1  
 If so, specify .....  
 (Signed) P. De Maria, M. D.  
 (Address) Supr 720 Genl Hosp

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. AGE should be stated EXACTLY. PHYSICIANS should state EXACTLY. PHYSICIAN should state EXACTLY. PHYSICIAN should state EXACTLY.

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**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 \_\_\_\_\_

Registered Apprentice No. \_\_\_\_\_, working under my personal supervision.

Signed \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

**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 this body is not embalmed, above space should be left blank.**

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

5352 -  
Do not use this space.

### 1. PLACE OF DEATH

(a) County Jackson Registration District No. 399  
 (b) Township N.C. Primary Registration District No. 1007 Registered No. 551  
 (c) City N.C. (d) Street No. Ben. Strop 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

Walter Murrell  
 (a) Residence, No. 1707 Ball Ave St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

### PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED M  
(write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
40 3 14

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
 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.

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

13. NAME

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

15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 2/9 1939 Dr. H. Crowe  
 Local Registrar.

### MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb. 9 - 1939

22. I HEREBY CERTIFY, That I attended deceased from 19... to 19...

I last saw h... alive on 19... Death is said to have occurred on the date stated above, at... m.

The principal cause of death and related causes of importance were as follows:

Acute bacterial endocarditis -  
Multiple abscesses liver  
Gallbladder and Kidneys  
 Other contributory causes of importance:  
Prob malignancy (tuberculosis)

Date of onset

Pulmonary edema

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.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify (Signed) P. F. De Maria, M. D.

(Address) Ben. Strop

SUPPLEMENT

