

11-1-1
5-1-1
I, X21492

Registration District No. 395 Primary Registration District No. 5551A Registrar's No. _____

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Lee's Summit Blue Springs
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution Shi A Bar Twp Woods Chapel Road & Blue Springs
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2
In this community 30 Years
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Blue Springs Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Woods Chapel & Blue Springs 3 miles SW Blue Springs
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 24th
year 1940 hour 2 minute P. M.

21. I hereby certify that I attended the deceased from July 15
1940 to July 28, 1940,
that I last saw her alive on July 24, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Depression of Respiration
Due to metastatic Carcinoma
Duration 2 weeks
10 years

Other conditions (Include pregnancy within 3 months of death)
Mo.

PHYSICIAN
Major findings:
Of operations:
Of autopsy:
Underline the cause to which death should be charged statistically.

8. (a) PRINT FULL NAME Miss Nellie L. Murray
8. (b) If veteran, name war None
3. (c) Social Security No. None

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased August 22 1891
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
48 11 2 hr. min.

9. Birthplace Colorado Springs Colorado
(City, town, or county) (State or foreign country)

10. Usual occupation Book Keeper (Retired)

11. Industry or business Fidelity Deposit Co. K.C.

MOTHER FATHER
12. Name Ray L. Murray
13. Birthplace Illinois
(City, town, or county) (State or foreign country)
14. Maiden name Mary Elizabeth Armstrong
15. Birthplace Oxford Pennsylvania
(City, town, or county) (State or foreign country)

16. (a) Informant Carroll D. McCollison
(b) Address Blue Springs, Mo.

17. (a) Cremation (b) Date thereof July 26, 1940
(Burial, cremation, or removal) Kansas City, Missouri
(c) Place: burial or cremation D. W. Newcomer's Sons

18. (a) Signature of funeral director D. W. Newcomer's Sons
(b) Address Kansas City, Missouri

19. (a) Aug. 10, 1940 (b) Max Thomas Oster
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
981

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature J. H. Stewart (M. D. or other) Medical
Address Lee's Summit Date signed 7/24/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

8: West 3 rd Street
Steel Remount, Mo.
4-6; 7-8: 82
Thurs 10:30-12

W.S.

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 W.C. Newcomer Jr
Licensed Embalmer No. 4043
P. O. Address W.C.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 this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **25376**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **395**

Primary Registration District No. **5357A**

Registrar's No. _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County **Jackson**
(b) City or town **Smith-Bar**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME **Nellie L. Murray**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, divorced, **S** married.

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years **48** Months **11** Days **2** If less than one day _____ min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____
13. Birthplace _____ (City, town, or county) _____ (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____
(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(If outside city or town limits write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **24**
year **1940** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19 _____ to _____ 19 _____;
that I last saw him _____ alive on _____ 19 _____;
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral depression of respiration**
Due to **metastasis carcinoma**

Other conditions _____
(Include pregnancy within 3 months of death)
Major findings: **Primary site of malignancy was the left breast.**
Of operations _____
Of autopsy **SD**

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work _____ (Specify type of place) _____
Means of injury _____

23. Signature **D. D. Stewart** (M. D. or other) _____
Address **Leis Summit** _____

SUPPLEMENTARY

