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FULL BUREAU OF THE CENSUS
NOV 13 1944

Registration District No. **379**

Primary Registration District No. **1002**

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Marys Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 30 Yrs. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson **048**

(c) City or town Kansas City **8**
(If outside city or town limits, write "RURAL")

(d) Street No. 205 West 66th St. Terrace
(If rural, give location)

(e) If foreign born, how long in U. S. A? 0 years.

3. (a) PRINT FULL NAME Margaret Horne Murray

3. (b) If veteran, name war No

3. (c) Social Security No. No

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 26
year 1941 hour 6 minute A. M.

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife George Murray

6. (c) Age of husband or wife if alive ----- years

7. Birth date of deceased Sept. 26 1862
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Oct 20
1941 to Oct 26 1941
that I last saw her alive on Oct 25 1941
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>79</u>	<u>1</u>	<u>0</u>	<u>hr.</u> <u>min.</u>

Immediate cause of death Uraemia - Chronic Interstitial Nephritis

Due to 131B

Other conditions -----
(Include pregnancy within 3 months of death)

9. Birthplace Scotland **4**
(City, town, or county) (State or foreign country)

10. Usual occupation House Wife

11. Industry or business At Home

MOTHER FATHER

12. Name -----Horne **4**

13. Birthplace Scotland **4**
(City, town, or county) (State or foreign country)

14. Maiden name Jane Robertson **7**

15. Birthplace No Record **7**
(City, town, or county) (State or foreign country)

PHYSICIAN

Major findings: -----

Of operations -----

Of autopsy -----

Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Ray P. Swanson

(b) Address 205 West 66th St. Terrace

17. (a) Burial (b) Date thereof 10/27/41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Washington

18. (a) Signature of funeral director Mrs. C. L. Forster

(b) Address 918 Brooklyn

19. (a) 10/27/41 (b) M. M. Crowe
(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? -----

(Specify type of place)

While at work? ----- (e) Means of injury -----

23. Signature Herbert L. Mandy (M. D. or other) **7**
Address 814 West 4th Date signed 10-27-41

NOV 29 1941

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 Me

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

Signed J. Clay Shupperd

Licensed Embalmer No. 4179

P. O. Address T. C. Me

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, fact should be so stated above.