

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

FORM 1-1935

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

17835

FILED JUN 9 1942
Registration District No. 237

Primary Registration District No. 4-1-4-4

State File No. _____
Registrar's No. 18

1. PLACE OF DEATH:

(a) County Dade Center Twsp.
(b) City or town Greenfield, Mo.
(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 Many years. (Specify whether
years, months or days)

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.

3. (a) PRINT FULL NAME Irvin E. Murdock.

8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Wife 6. (c) Age of husband or wife if alive 60 years
Cordelia Brown Murdock.
7. Birth date of deceased Dec. 20 1881.
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
60 4 9 _____ hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER
12. Name Albert Murdock
13. Birthplace Iowa
(City, town, or county) (State or foreign country)
14. Maiden name Theodicia Huff
15. Birthplace Iowa
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Harmer Murdock
(b) Address Greenfield, Mo.
17. (a) Burial (b) Date thereof May 5, 42.
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Greenfield Cem.

18. (a) Signature of funeral director J. W. Ward
(b) Address Greenfield, Mo.
19. (a) May 8 (b) Phyllis Lack
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 1st
year 1942 hour 9:00 minute _____ A. M.

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

Immediate cause of death Heart Failure Duration
Drank Strychnine Sulfate

Due to _____
Due to Poison 163 E

Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations _____
Of autopsy no autopsy

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) Suicide
(b) Date of occurrence May 1 1942
(c) Where did injury occur? Greenfield Dade Mo.
(City or town) (County) (State)
(d) Did injury occur in or about home, or farm, in industrial place, in public place?
Home

While at work? _____ (Specify type of place)
(e) Means of injury _____
28. Signature L. D. Dinniddie (M. D. or other) Coroner
Address Dadeville Mo Date signed 5-12-42

RECEIVED

District Health Officer No. 6,

District File Number 642-271

Date Filed JUN. 8 1942

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 J. W. Ward

Licensed Embalmer No. 2832

P.-O. Address Greenfield Mo

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. 178 35

Registration District No. 237

Primary Registration District No. 5323

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Wade

(b) City or town Rural - Sheffield
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Wade

(c) City or town Arcola
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Irvin E. Murdock

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

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

7. Birth date of deceased Dec 30 1884
(Month) (Day) (Year)

8. AGE: Years 60 Months 4 Days _____ 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) May 8 '42 (b) Phyllis Lacks
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day _____ year 1942 hour _____ minute _____ M.

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

Immediate cause of death _____

Due to _____

Due to _____

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

Major findings:
Of operations _____

Of autopsy _____

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)

(e) Means of injury _____

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

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

SUPPLEMENTARY

