7. S. No. 2
00M—2-43
5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 8 1943

Registration District No. 149

STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

20529

State File No.

Registrar's No. 2845

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: Trinity Lutheran
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 3 days (Specify whether years, months or days)
In this community: 3 days

2. USUAL RESIDENCE OF DECEASED: 999
(a) State: Kansas (b) County: 14
(c) City or town: La Cygne
(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: 9

3. (a) PRINT FULL NAME: Dr. Charles Murray
3. (b) If veteran, name war: No
3. (c) Social Security No.: None
4. Sex: Male
5. Color or race: Wh
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Nellie Murray
6. (c) Age of husband or wife if alive: 43 years
7. Birth date of deceased: October (Month) 11 (Day) 1883 (Year)

8. AGE: Years 59 Months 8 Days 8 If less than one day hr. min.

9. Birthplace (City, town, or county) Indiana (State or foreign country)
10. Usual occupation: Veterinarian
11. Industry or business
MOTHER FATHER
12. Name: Hosa Murray
13. Birthplace (City, town, or county) Indiana (State or foreign country)
14. Maiden name: Louisa Hawkins
15. Birthplace (City, town, or county) Indiana (State or foreign country)
16. (a) Informant: Mrs. Nellie Murray
(b) Address: La Cygne Kansas
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 6-25-43 (Month) (Day) (Year)
(c) Place: burial or cremation: La Cygne Kans.
18. (a) Signature of funeral director: Quirk and Polin
(b) Address: 20 N Linwood
19. (a) 6-25-43 (Date received local registrar) (b) P. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 19 1943.
year hour 3:30 a.m. minute M.

21. I hereby certify that I attended the deceased from June 15, 1943, to June 19, 1943, that I last saw him alive on June 18, 1943, and that death occurred on the date and hour stated above.

| Immediate cause of death | Duration |
|---|---|
| Hypostatic Pneumonia | 4 or 5 days |
| Due to | |
| Due to H 6 | |
| Other conditions (Include pregnancy within 3 months of death) | |

Major findings: Carcinoma of terminal ileum - complete obstruction
Of operations
Of autopsy yes

PHYSICIAN — Underline 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? (Specify type of place)
While at work (e) Means of injury

23. Signature: Geo. B. Norvary (M. D. or other)
Address: Professional Bldg. Date signed 6-19-43

(Licensed Embalmer's Statement on Reverse Side)

## 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 Harlyn Roe, Registered Apprentice No. ....., working under my personal supervision.

Signed Harlyn Roe

Licensed Embalmer No. 2810

P. O. Address K. C. 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, fact should be so stated above.**