S. No. 2
M—8-43
5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 1 1944

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 13800

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1661

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. Joseph Hospital 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 48 hrs (Specify whether
In this community 70 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson 48
(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")
(d) Street No. 640 East 73rd St. 8
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME MRS. CATHERINE A. MURRAY

3. (b) If veteran, name war No
3. (c) Social Security No. None

4. Sex Female
5. Color or race White 1
6. (a) Single, widowed, married, divorced Widow 2
6. (b) Name of husband or wife John T.
6. (c) Age of husband or wife if alive years
7. Birth date of deceased October (Month) 31st (Day) 1868 (Year)

8. AGE: Years 75 Months 5 Days 12 If less than one day hr. min.

9. Birthplace Springfield (City, town, or county) Illinois 1 (State or foreign country)
10. Usual occupation Housewife
11. Industry or business
FATHER
12. Name Thomas Eagan
13. Birthplace (City, town, or county) Ireland 4 (State or foreign country)
MOTHER
14. Maiden name No Record
15. Birthplace (City, town, or county) Ireland 4 (State or foreign country)
16. (a) Informant Frank Murray
(b) Address 640 East 73rd Street
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/15/44 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery
18. (a) Signature of funeral director Quirk and Robin Co
(b) Address 20 W. Linwood
19. (a) 4-14-44 (Date received local registrar) (b) D. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr. day 13
year 1944 hour 12: minute 05 A. M.
21. I hereby certify that I attended the deceased from Feb. 26th, 1943 to 4/12, 1944
that I last saw her alive on 4/12/44, 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Hypertensive Heart Disease	1 yr
Due to Hypertension	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

93d

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?
(Specify type of place)
While at work? (e) Means of injury
23. Signature James D Smith (M. D. or other)
Address 318 Prof. Bldg. Date signed 4/14/44
K.C. Mo.

(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.....

....., 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, fact should be so stated above.