S. No. 2
OM—5-43
v. 5-17-39
I X36671

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

117

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 17416

FILED MAY 17 1944

Registration District No. 1/
Primary Registration District No. 1000
Registrar's No. 439

1. PLACE OF DEATH:
(a) County Buchanan
(b) City or town St Joseph (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution 2913 St Joseph Ave (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ___ In this community abt 28 yrs. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Buchanan
(c) City or town St Joseph (If outside city or town limits, write "RURAL")
(d) Street No. 2913 St Joseph Ave (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME CHLOE - BRIGHT -
3. (b) If veteran, name war no
3. (c) Social Security No. no

4. Sex Fem
5. Color or race Wht
6. (a) Single, widowed, married, divorced Wed
6. (b) Name of husband or wife John Frank.
(c) Age of husband or wife if alive ___ years
7. Birth date of deceased June 10 (Month) (Day) (Year)

8. AGE: Years 65 | Months | Days | If less than one day ___ hr. ___ min.

9. Birthplace DeKalb Co, Mo, 0 (City, town, or county) (State or foreign country)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name James Murphey
13. Birthplace Buchanan Co Mo 0 (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Mary A. Call
15. Birthplace Buchanan Co Mo (City, town, or county) (State or foreign country)

16. (a) Informant Walter E Brown
(b) Address R
17. (a) -R- (Burial, cremation, or removal) (b) Date thereof Apr. 21 1944 (Month) (Day) (Year)
(c) Place: burial or cremation Union Star - Mo
18. (a) Signature of funeral director Stanley Funeral Home
(b) Address St Joseph Mo
19. (a) 4/21/44 (Date received local registrar) (b) Roe Herzog (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 19 year 1944 hour 12:15 minute P M.

21. I hereby certify that I attended the deceased from 1-28, 1944 to 4-19, 1944; that I last saw her alive on 4-19, 1944; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to Cerebral Hemorrhage	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

83a

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 Will W Graves DO (M. D. or other)
Address 722 Logan B. city Date signed 4/19/44

1233

(Licensed Embalmer's Statement on Reverse Side)

Dr. A. A. Graves
87 Edmond

AUG 18 1944

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.

MAY 19 1944

Signed John Roy Stanley

Licensed Embalmer No. 2435

P. O. Address St Joseph

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.