

No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **13807**

FILED MAY 2 1945

Registration District No. **175**

Primary Registration District No. **3036**

Registrar's No. **23**

1. PLACE OF DEATH:

(a) County Lawrence

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

(c) Name of hospital or institution:
702 East Highland
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community 50 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lawrence

(c) City or town Anna, Mo. 53
(If outside city or town limits, write "RURAL")

(d) Street No. 702 East Highland
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME Frank Jefferson Murray

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 27
year 1945 hour 10 minute 10 P.M.

4. Sex Male 5. Color or race _____ 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Alice 6. (c) Age of husband or wife if alive 66 years

7. Birth date of deceased Aug 18, 1867
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 2/24 1945 to 2/27 1945
that I last saw him alive on 2/27 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Lober Pneumonia 4 days
Duration

8. AGE: Years 77 Months _____ Days _____ If less than one day
hr. _____ min. _____

Due to _____

Due to _____

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

10. Usual occupation Miner

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

Major findings: Of operations 10/1

11. Industry or business

12. Name Jessie Murray

13. Birthplace unknown 9
(City, town, or county) (State or foreign country)

14. Maiden name Sarah Shinner

15. Birthplace unknown 4
(City, town, or county) (State or foreign country)

PHYSICIAN

Underline the cause to which death should be charged statistically.

16. (a) Informant Alice Murray

(b) Address Anna, Mo.

17. (a) burial (b) Date thereof 2/30/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Maple Park

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? _____

18. (e) Signature of funeral director Wayne M. Cleaver

(b) Address Anna, Mo.

19. (a) April 5, 1945 (b) Anna, Mo.
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place) (e) Means of injury 9

23. Signature Wayne M. Cleaver (M. D. or other) D.O.
Address Warrentonville, Mo. Date signed 3/2/45

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

MOTHER FATHER

1156

RECEIVED
District Health Officer No. 6,
District File Number 445-453
Date Filed APR 19 1945

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.....

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

Signed Oran L. Marsh
Licensed Embalmer No. 3812
P. O. Address Amoria 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.

Registration District No. 175 Primary Registration District No. 3036

1. PLACE OF DEATH:
(a) County Lawrence
(b) City or town Amora
(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)

3. (a) PRINT FULL NAME Frank J. Munac
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 _____

7. Birth date of deceased Aug 1909
(Month) (Day) (Year)

8. AGE: Years 77 Months _____ Days _____
If less than one day _____ hr. _____ 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) _____ (b) _____
(Date received local registrar) (Registrar's signature)

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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month _____ day _____
year _____ hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____;
that I last saw him/her alive on _____, 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)

PHYSICIAN
Major findings:
Of operations _____
Of autopsy _____
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 _____

SUPPLEMENTARY

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

13807