

No. 2
-12-45
-17-39
X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11323

State File No.

Registrar's No. **2465**

Registration District No. **318**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County **St. Louis**
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution **Desloge Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1 day**
(Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **000**
(c) City or town **St. Louis, Mo.** **517**
(If outside city or town limits, write "RURAL")
(d) Street No. **5560 Cates Ave.** **9**
(If rural, give location) **0**
(e) Citizen of foreign country? **No.** (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME **ROBERT PARKER MURRAY**

3. (b) If veteran, name war..... 3. (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 **Carrie Strong** 6. (c) Age of husband or wife if alive **80** years

7. Birth date of deceased **Feb. 7, 1863**
(Month) (Day) (Year)

8. AGE: Years **84** Months **1** Days **1** If less than one day
hr. min.

9. Birthplace **Halifax, N.S., Canada** **2**
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired Train Auditor**

11. Industry or business **Mo. Pac. R.R.**

MOTHER FATHER

12. Name **William Murray**

13. Birthplace **Halifax, N.S., Canada** **2**
(City, town, or county) (State or foreign country)

14. Maiden name **Martha Elliott**

15. Birthplace **Halifax, N.S., Canada** **2**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. R. P. Murray**

(b) Address **5560 Cates Ave.**

17. (a) **Cremation** (b) Date thereof **3-10-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Oak Grove Crematory**

18. (a) Signature of funeral director **Alexander & Sons**
(b) Address **6175 Delmar Blvd., St. Louis, Mo.**

19. (a) **MAR 10 1947** **J. F. Bredeck**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **8th**
year **1947** hour **5:35** minute **A.** M.

21. I hereby certify that I attended the deceased from **Feb. 24th** 19 **47** to **March 6th** 19 **47**;
that I last saw him alive on **March 6th, 1947** 19 **47**;
and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic Myocarditis** Duration **10 years**

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) (c) Means of injury **0**

23. Signature **R.D. Tueling** (M. D. or other) **M. D.**

Address **7161 Delmar.** Date signed **3/8/47**

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 Jos. E. McCulloch
Licensed Embalmer No. 2460
P. O. Address 617 1/2 Delmar

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.