

FILED AUG 25 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 29048

BIRTH NO. _____		REG. DIST. NO. <b>317</b>		PRIMARY REG. DIST. NO. <b>6076</b>		Registrar's No. <b>1904</b>	
1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Koch (rural)</b>		c. LENGTH OF STAY (in this place) <b>40 days</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		<b>2239</b>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>Robert Koch Hospital</b>				d. STREET ADDRESS (If rural, give location) <b>1517a South 3rd</b>			
3. NAME OF DECEASED (Type or Print)		a. (First) <b>Edward</b>		b. (Middle) <b>Earl</b>		c. (Last) <b>Murray</b>	
4. DATE OF DEATH (Month) (Day) (Year) <b>August 6, 1950</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Separated</b>	
8. DATE OF BIRTH <b>11-17-99</b>		9. AGE (In years last birthday) <b>50</b>		IF UNDER 1 YEAR Months Days		IF UNDER 2 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Esther, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>William Murray</b>		13b. MOTHER'S MAIDEN NAME <b>Sarah Edwards</b>		14. NAME OF HUSBAND OR WIFE <b>Dexter Bradley Murray</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>488-07-8875</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Hospital Records, Robt. Koch Hosp.</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Squamous Cell Carcinoma of Larynx</b>				INTERVAL BETWEEN ONSET AND DEATH <b>15 mo. (?)</b>	
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____				16/KA	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Pulmonary Tuberculosis, Activity Questionable</b>		15 mo. (?)					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>6-27-50</b> , 19____, to <b>8-6-50</b> , 19____, that I last saw the deceased alive on <b>8-6-50</b> , 19____, and that death occurred at <b>7:25 P.m.</b> , from the causes and on the date stated above.							
23a. SIGNATURE <b>Edwin J. Lipsitz, M.D.</b>				23b. ADDRESS <b>Robert Koch Hospital</b>		23c. DATE SIGNED <b>8-7-50</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL U</b>		24b. DATE <b>AUG. 9-1950</b>		24c. NAME OF CEMETERY OR CREMATORY <b>NATIONAL CEMETERY</b>		24d. LOCATION (City, town, or county) (State) <b>JEFFERSON BARRACKS, MO</b>	
DATE REC'D BY LOCAL REG. <b>AUG 8 1950</b>		REGISTRAR'S SIGNATURE <b>Herbert P. Donker, M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>A. STOCK 2117 E. GRAND AVE.</b>			

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

SEP 12 1980

**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.....

Student Embalmer No. ....

working under my personal supervision.

Student .....  
Student Embalmer

Signed *Frank A. Moore*

Licensed Embalmer No. 3041

P. O. Address 2117 E. St.

**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.