

FILED JAN 26 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

2844

State File No.

528

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No.

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. LENGTH OF STAY (In this place) <u>19 Days</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION. <u>St. Johns Hospital</u>		d. STREET ADDRESS (If rural, give location) <u>710 Ponce St.</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Robert</u>	b. (Middle) <u>E</u>	c. (Last) <u>Murray, Sr.</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Jan 16 1951</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Oct 7, 1899</u>	9. AGE (In years last birthday) <u>51</u>	# UNDER 1 YEAR Months <u>3</u>	Days <u>9</u>	# UNDER 12 HRS. Hours <u></u>	Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Locomotive Engineer M.K.T. Railroad</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>M.K.T. Railroad</u>	11. BIRTHPLACE (State or foreign country) <u>Texas</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Robert C. Murray</u>	13b. MOTHER'S MAIDEN NAME <u>Dora Griffin</u>	14. NAME OF HUSBAND OR WIFE <u>Jessie Murray</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes World War #1</u>	16. SOCIAL SECURITY NO. <u>702,10,2716</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Jessie L. Murray</u>	ADDRESS <u>710 Ponce St.</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cardiac decompensation</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 mo.</u> <u>2 yrs.</u> <u>years.</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Myocardial infarction</u>		
	DUE TO (c) <u>Hypertensive C-V disease</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>H2O1</u>
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22. I hereby certify that I attended the deceased from Sept, 1948, to Jan, 1951, that I last saw the deceased alive on Jan 16, 1951, and that death occurred at 11:40 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Wm C. Macomber M.D.</u>	23b. ADDRESS <u>539 N. Grand</u>	23c. DATE SIGNED <u>1-18-51</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Jan 20, 1951</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Friedens Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>St. Louis County Mo.</u>
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DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>JAN 18 1951 J. B. Laster</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Buchholz Koeller 5967 W Florissant A</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....

working under my personal supervision.

Student Embalmer No.....

Signed *William G. Bushholz*

Signed.....
Student Embalmer

Licensed Embalmer No. *2110*

P. O. Address *St. Louis 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.