No. 300
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

FILED NOV 22 1954

THE DIVISION OF HEALTH OF MISSOURI
# STANDARD CERTIFICATE OF DEATH

State File No. 39472

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 541 Registrar's No. 2392

**1. PLACE OF DEATH**
a. COUNTY: St. Louis
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Clayton
c. LENGTH OF STAY (In this place): D.O.A.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Louis County Hosp.

**2. USUAL RESIDENCE** (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: St. Louis
c. CITY OR TOWN: Clayton
d. Is Residence within limits of a city or incorporated town? Yes ☐ No ☐
e. STREET ADDRESS (If rural, give location): Ann Avenue-Rt. 1-Box 99

**3. NAME OF DECEASED** (Type or Print): a. (First) Charles b. (Middle) A. c. (Last) Murray

**4. DATE OF DEATH** (Month) (Day) (Year): Oct. 9, 1954

**5. SEX**: Male

**6. COLOR OR RACE**: Negro

**7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED** (Specify): Married

**8. DATE OF BIRTH**: Feb. 17, 1884

**9. AGE** (In years last birthday): 70 — If under 1 year: Months 7, Days 22 — If under 24 hrs.: Hours, Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Caretaker

**10b. KIND OF BUSINESS OR INDUSTRY**: unk

**11. BIRTHPLACE** (City and State or Foreign Country): St. Clair, Missouri

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13a. FATHER'S NAME**: John Murray

**13b. MOTHER'S MAIDEN NAME**: Elizabeth Jamison

**14. NAME OF HUSBAND OR WIFE**: Berintha Murray

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown): No (If yes, give war or dates of service)

**16. SOCIAL SECURITY NO.**: None

**17. INFORMANT'S SIGNATURE OR NAME**: Berintha Murray — ADDRESS: Ann Ave. Rt.1 Box 99

**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, asthenia, etc. It means the disease, injury, or complication which caused death.*

**MEDICAL CERTIFICATION**

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) unknown natural causes — INTERVAL BETWEEN ONSET AND DEATH: unk

ANTECEDENT CAUSES

*Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b) _____

DUE TO (c) _____

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**: 7955

**20. AUTOPSY?** YES ☐ NO ☒

**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 ☐ NOT WHILE AT WORK ☐

**21f. HOW DID INJURY OCCUR?**

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

**23a. SIGNATURE** (Degree or title): Herbert R. Domke, M.D., Local Registrar

**23b. ADDRESS**: 651 S. Brentwood Blvd.

**23c. DATE SIGNED**: 11/8/54

**24a. BURIAL, CREMATION, REMOVAL** (Specify): Burial

**24b. DATE**: 10/14/1954

**24c. NAME OF CEMETERY OR CREMATORY**: Greenwood Cemetery

**24d. LOCATION** (City, town, or county) (State): St. Louis, Missouri

DATE REC'D BY LOCAL REG.: 10/12/54

REGISTRAR'S SIGNATURE: Herbert R. Domke M.D.

**25. FUNERAL DIRECTOR'S SIGNATURE**: Charles J. Gates — ADDRESS: 4107 Finney Ave.

(Licensed Embalmer's Statement on Reverse Side)

## STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embal

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed R. L. Cummings

Licensed Embalmer No. 436

P. O. Address 4107 Finney

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Fai
to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.