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FILED AUG 2 - 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

24152
State File No. 6012
Registrar's No.

BIRTH NO. REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH
a. COUNTY MISSOURI
2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE MISSOURI b. COUNTY

b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS
c. LENGTH OF STAY (in this place)
c. CITY OR TOWN ST. LOUIS
d. Is Residence within limits of a city or incorporated town? Yes No

d. FULL NAME OF HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSPITAL
e. STREET ADDRESS (If rural, give location) 23 1304 South 9th 22390

3. NAME OF DECEASED (Type or Print) a. (First) MAE b. (Middle) c. (Last) MURREY
4. DATE OF DEATH (Month) (Day) (Year) JULY 10 1955

5. SEX FEMALE 6. COLOR OR RACE WHITE 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOW 8. DATE OF BIRTH APRIL 4, 1895 9. AGE (In years last birthday) 60 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (City and State or Foreign Country) MISSOURI 12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME WM. CAPPS 13b. MOTHER'S MAIDEN NAME CATHERINE GREEN 14. NAME OF HUSBAND OR WIFE UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. 17. INFORMANT'S SIGNATURE OR NAME ADDRESS HOSPITAL RECORD

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) Cerebral Thrombosis
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.
ANTECEDENT CAUSES DUE TO (b) Cerebral Arteriosclerosis
Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (c)
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Generalized Arteriosclerosis

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION 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) (Min.) 21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR? 332X

22. I hereby certify that I attended the deceased from 7-9-55, 19__, to 7-10-55, 19__, that I last saw the deceased alive on 7-10-55, 19__, and that death occurred at 6:15P m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) 23b. ADDRESS 1515 Lafayette Avenue 23c. DATE SIGNED 7-11-55

24a. BURIAL, CREMATION REMOVAL (Specify) 24b. DATE JULY 13 1955 24c. NAME OF CEMETERY OR CREMATORY RESURRECTION 24d. LOCATION (City, town, or county) (State) ST. LOUIS MO

DATE REC'D BY LOCAL REG. JUL 12 1955 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 2906
2nd S (Licensed Embalmer's Statement on Reverse Side)

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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....
Samuel Hill

Licensed Embalmer No. 434

P. O. Address 2906 St

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F 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.