

Health, Welfare & Public Services
 300
 1-58
 All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

26801

FILED JUL 22 1957

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 1724

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>St. Louis</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	a. STATE <u>Mo.</u>	b. COUNTY <u>St. Louis</u>
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Clayton</u>		c. CITY OR TOWN <u>Kinloch 4091</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Louis County Hosp.</u>	Length of stay in 1b <u>4 wks</u>	d. STREET ADDRESS (If outside, give location) <u>957 Fifth Avenue</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH	
First <u>Preston</u>	Middle	Last <u>Murray</u>	Month <u>7</u>	Day <u>7</u> Year <u>1957</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	
	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<u>20 March 1884</u>	
9. AGE (In years last birthday) <u>73</u>		10. KIND OF BUSINESS OR INDUSTRY <u>Laborer</u>		11. BIRTHPLACE (City and state or country) <u>Westpoint, Ga.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Porter</u>		11. BIRTHPLACE (City and state or country) <u>Westpoint, Ga.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Howard Murray</u>		14. MOTHER'S MAIDEN NAME <u>Edna Mosby</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>494-01-5343</u>		17. INFORMANT <u>Cora Murray</u> Address <u>957 Fifth Avenue</u>

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:		
IMMEDIATE CAUSE (a) <u>Pulmonary Infarct</u>		<u>12 hrs.</u>
Conditions, if any, which gave rise to above cause (b), stating the underlying cause last.	DUE TO (b) <u>Arteriosclerotic Heart disease</u>	
	DUE TO (c) <u>Generalized Arteriosclerosis.</u>	<u>4200</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
<u>Rest up + Prostate Multiple Amp of Bladder gangrene - 17 Dec.</u>		

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE

21. I attended the deceased from 5-29-57 to 7-7-57 and last saw her ^{alive} on 7-7-57
 Death occurred at 4:45 A. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Irish L. Hagador, MD 22b. ADDRESS 601 S. Brentwood 22c. DATE SIGNED 7/9/57

23a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial 23b. DATE 15 July '57 23c. NAME OF CEMETERY OR CREMATORY Washington Park 23d. LOCATION (City, town, or county) (State) St. Louis County, Mo.

24. FUNERAL DIRECTOR ADDRESS Boyd Bros. Funeral Home, Kinloch, Mo. 25. DATE RECD. BY LOCAL REG. 7-9-57 26. REGISTRAR'S SIGNATURE Hebert K. Sontke, MD

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 *Edward J. Flynn*

Licensed Embalmer No. *44*

P. O. Address *So. Kinloch*

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