

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-011229

STATE FILE NUMBER

Registration No. 2236

FILED MAR 17 1959

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registration No. 2236

300  
1-57  
8  
1491  
0

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>St. Louis</b>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>D.O.A. Lutheran Hosp.</b>		Length of stay in 1b		d. STREET ADDRESS (If outside, give location) <b>5838 Neosho</b>	
3. NAME OF DECEASED (Type or print) <b>William A. Murdoch</b>			4. DATE OF DEATH Month <b>March</b> Day <b>2</b> Year <b>1959</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 16, 1885</b>	9. AGE (In years last birthday) <b>73</b> IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Minister</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Church Presbyterian</b>		11. BIRTHPLACE (City and state or country) <b>East Kilbride, Scotland 4</b>	
13a. FATHER'S NAME <b>Peter Murdoch</b>		13b. MOTHER'S MAIDEN NAME <b>Agnes Anderson</b>		14. NAME OF HUSBAND OR WIFE <b>Irene W. Murdoch (Dec.)</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>493-40-4897</b>		17. INFORMANT <b>Mrs. June Williamson, 12963 Greenleaf St.</b> Address <b>Hollywood, Calif.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b>					INTERVAL BETWEEN ONSET AND DEATH <b>? 6 hrs.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Coronary Heart Disease</b>					
DUE TO (c) <b>Generalized Arteriosclerosis 420.1</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Pneumonia by Acute Pharyngitis + Bronchitis.</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2
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 Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE 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 <b>Dec. 1950</b> to <b>March, 1959</b> and last saw him alive on <b>March 1, 1959</b> Death occurred at <b>Approx. 12:30 PM.</b> in on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>Charles J. Hernandez M.D.</b>			22b. ADDRESS <b>4401 Hampton</b>		22c. DATE SIGNED <b>3/2/59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE <b>3-5-1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Valhalla Crematory</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis County</b>
24. FUNERAL DIRECTOR ADDRESS <b>HOFFMEISTER COLONIAL LORTUARY</b>			25. DATE RECD. BY LOCAL REG. <b>MAR 4 '59</b>		26. REGISTAR'S SIGNATURE <b>Loard Smith. M.D.</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

6464 Chippewa Street, St. Louis

(Licensed Embalmer's Statement on Reverse Side)

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.

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 *Rich C. Brown* .....

Licensed Embalmer No. *7764* .....  
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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.