

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

24510

1. PLACE OF DEATH

County Jackson Registration District No. 399 File No. 8239
 Township 1st Primary Registration District No. 1002 Registered No. 8239
 City H. B. MO (No. 1123) Worton St. _____ Ward _____

2. FULL NAME

John S. Murphy
 (a) Residence. No. 1123 Worton Ave St. 12 Ward. _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widowed
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF W.
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 13-1855
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. 72 11 13
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work minor
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) Mo

PARENTS

10. NAME OF FATHER unknown
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) unknown
 12. MAIDEN NAME OF MOTHER unknown
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) unknown

14. INFORMANT William Johnson (Address) 1723 Worton

15. FILED 9/26, 1927 M. M. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 26 1927
 17. I HEREBY CERTIFY, That I attended deceased from 8/25/27 to 8/25/27, 1927, that I last saw him, alive on 8/25/27, 1927, and that death occurred, on the date stated above, at 7:10 am

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Bronchial Pneumonia
107 H
167
1000 (duration) 2 ds.
 CONTRIBUTORY aged eye (SECONDARY) (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH, _____
 19. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
 WAS THERE AN AUTOPSY? _____
 WHAT TEST CONFIRMED DIAGNOSIS? _____
 (Signed) D. P. Russell M. D.
9/26, 1927 (Address) 3231 E. 16 St.
 *State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Camden Mo DATE OF BURIAL _____ 19 _____

20. UNDERTAKER Rose & Co. ADDRESS 158 Jackson

Dr. Arnold
1977

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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Jackson
Township Jackson
City Jackson City (No.) St. Ward)

Registration District No. 399
Primary Registration District No. 1002

File No.
Registered No. 3299

2. FULL NAME

(a) Residence. No. St. Ward John S. Murphy
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

m

4. COLOR OR RACE

w

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

wid

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

Sept 13 - 1854

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

72

11

13

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT (Address)

15. FILED 8/26 27 M. M. Brown REGISTRAR
ass

16. DATE OF DEATH (MONTH, DAY AND YEAR)

Aug 26 1927

17.

I HEREBY CERTIFY That I attended deceased from 19....., 19..... that I last saw h..... alive on 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed)....., M. D
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

REGISTRARS SHALL NOT RECEIVE DATE UNTIL THEY

SUPPLEMENTARY

015h2-5