

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

Do not use this space.

5517
810

MAR 20 1935

1. PLACE OF DEATH

County Jackson Registration District No. 399
 Township Jackson Primary Registration District No. 1002
 City Kansas City (No. K.C. General Hosp.) St. _____ Ward _____

2. FULL NAME

(a) Residence, No. Murphy Street Ward _____
 (Usual place of abode) 2925 Huntington

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb-3-1857

7. AGE YEARS 78 MONTHS 0 DAYS 17 If LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION
 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. None
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana

FATHER
 13. NAME William Murphy

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana

MOTHER
 15. MAIDEN NAME Unknown

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana

17. INFORMANT (ADDRESS) Reverend Clerk K.C.M.H.

18. BURIAL, CREMATION, OR REMOVAL PLACE St. Peter's Church DATE Feb 21, 1935

19. UNDERTAKER (ADDRESS) St. Peter's Church

20. FILED 2/21 1935 M.M. Crane Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-20, 1935

22. I HEREBY CERTIFY, That I attended deceased from 2-16, 1935, to 2-20, 1935

I last saw him alive on 2-20, 1935 Death is said to have occurred on the date stated above, at 10:50 a.m.

The principal cause of death and related causes of importance were as follows:

Chronic Nephritis
Aspirative Pneumonia
both lungs

Other contributory causes of importance:
 Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased?
 If so, specify _____
 (Signed) J. J. [Signature] M. D.
 (Address) K.C. General Hosp. K.C.M.H.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

