

Registration District No. 486

Primary Registration District No. 4293

Registrar's No. 36

1. PLACE OF DEATH: 2  
 (a) County Christian  
 (b) City or town Estancia  
 (c) Name of hospital or institution:  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution All his life (Specify whether years, months or days)  
 In this community 619

3. (a) PRINT FULL NAME Leoris H. Murphy  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced, Widow  
 6. (b) Name of husband or wife S. J. Murphy 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased Sept. 17 1856  
 (Month) (Day) (Year)

8. AGE: Years 83 Months 2 Days 6 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Lincoln Co. Mo.  
 (City, town, or county) (State or foreign country)

10. Usual occupation House wife

11. Industry or business \_\_\_\_\_  
 12. Name Leoris H. Murphy  
 18. Birthplace Mo. O  
 14. Maiden name Jessie Keeling  
 15. Birthplace Mo. O  
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature J. H. Murphy  
 (b) Address Trinity Lake S.W. J.  
 17. (a) Ch. Lewis (b) Date thereof 11 26 39  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Elmwood Cemetery

18. (a) Signature of funeral director W. A. Bradley  
 (b) Address Elmwood  
 19. (a) Dec. 10 (b) Estel Powell  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
 (c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_ (If rural, give location)  
 (e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 23  
 year 1939 hour 2 minute \_\_\_\_\_ P. M.  
 21. I hereby certify that I attended the deceased from Nov. 21, 1939 to \_\_\_\_\_, 19\_\_\_\_  
 that I last saw her alive on Nov. 21, 1939  
 and that death occurred on the date and hour stated above.

Immediate cause of death Apoplexy - Hypertension  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions (include pregnancy within 3 months of death) 4 1/2 in

Duration 3 days  
 PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically

Major findings: Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:  
 (a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
 (b) Date of occurrence \_\_\_\_\_  
 (c) Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? \_\_\_\_\_ (Specify type of place) (c) Means of injury \_\_\_\_\_  
 23. Signature Dr. H. C. Hunter (M. D. or other) \_\_\_\_\_  
 Address Elmwood, Mo. Date signed Nov 25

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.

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**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.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**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 this body is not embalmed, above space should be left blank.**