

NOV 13 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **33830**
3764
Registrar's No.

Registration District No. **297**

Primary Registration District No. **1002**

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 2457 Tracy
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 39 years (Specify whether
In this community 39 years (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 2457 Tracy
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Haywood Murphy

3. (b) If veteran, None name war. 3. (c) Social Security 710-03-8248 No.

4. Sex Male 5. Color or race Col 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Cora Murphy 6. (c) Age of husband or wife if alive 62 years

7. Birth date of deceased November 5, 1881
(Month) (Day) (Year)

8. AGE: Years 59 Months 10 Days 29 If less than one day
hr. min.

9. Birthplace Tenn
(City, town or county) (State or foreign country)

10. Usual occupation Pullman Company

11. Industry or business Pullman Company

12. Name Jack Murphy 13. Birthplace Tenn
(City, town or county) (State or foreign country)

14. Maiden name Easter 15. Birthplace Tenn
(City, town, or county) (State or foreign country)

16. (a) Informant Cora Murphy

(b) Address 2457 Tracy

17. (a) burial (b) Date thereof 10/8/41
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Highland Cemetery

18. (a) Signature of funeral director Hathorn Bros.
(b) Address 1729 Lydia

19. (a) 10/8/41 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 4th
year 1941 hour 11 minute 30 P. M.

21. I hereby certify that I attended the deceased from 4-1-41 to 10-4-41
that I last saw him alive on 10-4- and that death occurred on the date and hour stated above.

Immediate cause of death auricular fibrillation
Due to hypertensive type heart disease
Due to arterial sclerosis
Other conditions chronic bronchitis
(Include pregnancy within 3 months of death)

Major findings: None
Of operations None
Of autopsy None

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence no
(c) Where did injury occur? no (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? no

While at work? no (Specify type of place) (e) Means of injury no
23. Signature J. D. Wells (M. D. or other) 0
Address 1605 E. 78th St. Date signed 10/8/41

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

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. 3994

P. O. Address. 2503 Highland

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.