DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 31388

FILED OCT 7 1943

Registration District No. 53

Primary Registration District No. 5200

Registrar's No. 103

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

1. PLACE OF DEATH:

(a) County: Carroll

(b) City or town: ~~Carrollton~~ Wakenda twp
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 5
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... In this community: Entire Life
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo (b) County: Carroll

(c) City or town: Rural Wakenda Twp
(If outside city or town limits, write "RURAL")

(d) Street No. .....
(If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country: 0

3. (a) PRINT FULL NAME: OTA GROVER MURPHY

3. (b) If veteran, name war .....

3. (c) Social Security No. .....

4. Sex: M

5. Color or race: W

6. (a) Single, widowed, married, divorced: Single

6. (b) Name of husband or wife .....

6. (c) Age of husband or wife if alive ..... years

7. Birth date of deceased: Sept (Month) 8 (Day) 1881 (Year)

8. AGE: Years 62 | Months 0 | Days 9 | If less than one day ..... hr. ..... min.

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

10. Usual occupation: Farming

11. Industry or business .....

FATHER
12. Name: Jessie N. Murphy
13. Birthplace: Virginia (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Elizabeth Adams
15. Birthplace: Kentucky (City, town, or county) (State or foreign country)

16. (a) Informant: Lilburn Murphy
(b) Address: Wakenda, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 9-18-43 (Month) (Day) (Year)
(c) Place: burial or cremation: Adkins Cem.

18. (a) Signature of funeral director: L. Standley
(b) Address: Carrollton Mo

19. (a) 9-18-1943 (Date received local registrar) (b) Mrs James Rafferty (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 17 year 1943 hour 1 minute 00 A.M.

21. I hereby certify that I attended the deceased from 9-16-43 ....., 19..., to 9-17, 1943 that I last saw him alive on 9-17, 1943 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cirrhosis Liver	
Due to: Mitral Insufficiency	3
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations:	
Of autopsy:	

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 (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) (e) Means of injury .....

23. Signature: W. L. Atwood (M. D. or other)

Address: Carrollton, Mo Date signed 9/17/43

1.53

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,

District File Number.....
Date Filed 10-6-43

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 Ben W. Gibson

Licensed Embalmer No. 2961

P. O. Address Carrollton Mo

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

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

No. 2B
—543
I 136930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. ..... OCT - 1943

Registration District No. 55 Primary Registration District No. 5200 Registrar's No. 183

1. PLACE OF DEATH:

(a) County Carroll

(b) City or town Rural - Wakenda
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: County Farm.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether
In this community ..... years, months or days)

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) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME Ota Grover Murphy

3. (b) If veteran, name war .....

3. (c) Social Security No. .....

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced S

6. (b) Name of husband or wife .....

6. (c) Age of husband or wife if alive ..... years

7. Birth date of deceased Sept (Month) 8 (Day) 1881 (Year)

8. AGE: Years 62 Months 0 Days ..... If less than one day ..... hr. ..... min.

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

10. Usual occupation .....

11. Industry or business .....

FATHER
12. Name .....
13. Birthplace ..... (City, town, or county) ..... (State or foreign country)

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

16. (a) Informant .....
(b) Address .....

17. (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (Month) (Day) (Year)
(c) Place: burial or cremation .....

18. (a) Signature of funeral director .....
(b) Address .....

19. (a) ..... (Date received local registrar) (b) ..... (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Sept 17
year 1943 hour ..... minute ..... M.

21. I hereby certify that I attended the deceased from ..... 19.... to ..... 19....;
that I last saw h..... alive on ..... 19....;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions ..... (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

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 (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? ..... (Specify type of place)
While at work? ..... (e) Means of injury .....

23. Signature ..... (M. D. or other) .....
Address ..... Date signed .....

SUPPLEMENTARY

31388