

**FILED** AUG 7 1946  
Registration District No. 209

**STANDARD CERTIFICATE OF DEATH**  
Primary Registration District No. 3043

State File No. \_\_\_\_\_  
Registrar's No. 230

1. PLACE OF DEATH:

(a) County Marion

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

(c) Name of hospital or institution: 0  
(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 *Leavenworth Hospital*

3. (a) PRINT FULL NAME *Bessie Murphy*

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

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

4. Sex: *Female* Color or race *Negro*

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

6. (b) Name of husband or wife *Wm. Murphy*

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

7. Birth date of deceased *8 1 1921*  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<i>24</i>	<i>9</i>	<i>20</i>	hr. _____ min. _____

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

10. Usual occupation *Housewife*

11. Industry or business \_\_\_\_\_

12. Name *Robt Miller*

13. Birthplace *Ralls Mo*  
(City, town, or county) (State or foreign country)

14. Maiden name *Fannie Allison*

15. Birthplace *New London Mo*  
(City, town, or county) (State or foreign country)

16. (a) Informant *Wm. Murphy*

(b) Address *New London*

17. (a) *Burial* (b) Date thereof *5-23-46*  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation *New London*

18. (a) Signature of funeral director *G. E. Roberts*

(b) Address *Hannibal Mo*

19. (a) *7-8-46* (b) *E. M. Lucke*  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Mo* (b) County *Ralls* *87*

(c) City or town *New London* *1*  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_  
(If rural, give location) *1*

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No) *1*

If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month *5* day *21*  
year *46* hour *12* minute *30* A.M.

21. I hereby certify that I attended the deceased from *May 20*  
*1946*, to *May 21*, 19*46*

that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death *Severe Burns on face & body*

Due to \_\_\_\_\_

Due to \_\_\_\_\_

**ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED**

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) \_\_\_\_\_ *87*

(b) Date of occurrence \_\_\_\_\_ *6*

(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? *17*

While at work? \_\_\_\_\_  
(Specify type of place) (a) Means of injury

23. Signature *P. W. Fox* (M. D. or other) *2*

Address *Hannibal Mo* Date signed *7-5-46*

MOTHER FATHER

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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, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. Aug  
Registrar's No. \_\_\_\_\_

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Marrison  
(b) City or town Hannibal  
(If outside city or town limits, write "RURAL" and name of township)  
(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 \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days

3. (a) PRINT FULL NAME

Bessie Murphy

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex 7 5. Color or race B 6. (a) Single, widowed, married, divorced ma

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Aug (Month) 1 (Day) 1946 (Year)

8. AGE: Years 24 Months 9 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Steno.

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

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

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

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

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ Year 1946 Hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_, that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

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

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) accident ✓  
(b) Date of occurrence May 20, 1946  
(c) Where did injury occur? New London Falls Mo. (City or town) (County) (State) 6-  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? at home

While at work? \_\_\_\_\_ (Specify type of place) (c) Means of injury Severe Burns fatal

23. Signature J. W. Fox (M. D. or other) \_\_\_\_\_  
Address Hannibal, Mo. Date signed 8-28-46

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

880  
23181  
WALLS PLAINLY—USE UNFADING INK—MAKE A LEGIBLE RECORD

24328