

No. 2
-12-45
-17-39
X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **38332**
4861
Registrar's No.

FILED NOV 29 1947 149
Registration District No.

Primary Registration District No. 1002

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

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:
K.C.T.B. HOSPITAL
(If not in hospital or institution, write street number or location) 0
(d) Length of stay: In hospital or institution 26 days (Specify whether
In this community 58 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. 5827 E 11th
(If rural, give location)
(e) Citizen of foreign country? unknown (Yes or No)
If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOVEMBER, day 20
year 1947 hour 2²⁵ AM minute _____ M.
21. I hereby certify that I attended the deceased from
10-24-47, 19____, to 11-20, 1947
that I last saw him alive on 11-20, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death:
Pulmonary Tuberculosis.
Duration 3 yrs.

Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death)
Major findings: 3K
Of operations _____
Of autopsy _____

PHYSICIAN
Underline the cause to which death should be charged statistically.

3. (a) PRINT FULL NAME MURPHY, WILLIAM

3. (b) If veteran, name war no 3. (c) Social Security No. 486-26-0650

4. Sex M 5. Color or race WHITE 6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife unknown 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased AUGUST 9 1873
(Month) (Day) (Year)

8. AGE: Years 74 Months 3 Days 11 If less than one day _____ hr. _____ min.

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

10. Usual occupation NONE

11. Industry or business _____

MOTHER FATHER { 12. Name MURPHY, TIMOTHY

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

14. Maiden name COLEMAN, MARY

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

16. (a) Informant K.C.T.B. HOSPITAL

(b) Address LEEDS, MISSOURI

17. (a) Burial (b) Date thereof 11-22-47
(burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Mary's

18. (a) Signature of funeral director J. P. Sibus

(b) Address W. C. J. Co.
19. (a) 11-20-47 (b) Sheraldine Holmes
(Date received local registrar) (Registrar's signature)

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 0

Signature William David May (M. D. or other) M.D.
Address K.C.T.B. Hosp., K.C. 3 Mo. Date signed 11-20-47

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..... *John G. Shil*.....
Licensed Embalmer No..... *3655*.....
P. O. Address..... *R. C. Mo*.....

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.