

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **23129**
Registrar's No. **2785**

FILED JUL 19 1948 49
Registration District No. _____

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:
ST. DUKE'S HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **3 WEEKS** (Specify whether
In this community **LIFE** years, months or days)

3: (a) PRINT FULL NAME **KAREN MARIE MURPHY**
3. (b) If veteran, name war **NO** 3. (c) Social Security No. **NONE**

4. Sex **FEMALE** 5. Color or race **WHITE** 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 **MARCH - 5 - 1948**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 3 28 hr. min.

9. Birthplace **KANSAS CITY MISSOURI**
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name **FRANK J. MURPHY**
13. Birthplace **KANSAS CITY MISSOURI**
(City, town, or county) (State or foreign country)
14. Maiden name **BESSIE WHEELER**
15. Birthplace **KANSAS CITY KANSAS**
(City, town, or county) (State or foreign country)

16. (a) Informant **J. J. Murphy**
(b) Address **4436 Sunrise Drive**

17. (a) **BURIAL** (b) Date thereof **JULY - 6 - 1948**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **MEMORIAL PARK CEM.**

18. (a) Signature of funeral director **D. W. Thompson**
(b) Address **1401 Bond Street Bldg**

19. (a) **7-6-48** (b) **Deraldine Johnson**
(Date received local registrar) (Registrar's signature)

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. **4436 Sunrise Drive**
(If rural, give location)
(e) Citizen of foreign country? **NO** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **3**
year **1948** hour **5** minute **47 P** M.

21. I hereby certify that I attended the deceased from **Pathologist**, 19____, that I last saw him alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death **Multiple pulmonary embolus**
Due to **staphylococcus**
Due to **fibrosis disease of pancreas**

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations **128**
Of autopsy **same**

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 **1**

23. Signature **C. D. Knudsen** (M. D. or other) _____
Address **St. Luke's Hospital** Date signed _____

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

3 July 1948

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 Robert Ray

Licensed Embalmer No. 4182

P. O. Address. Kansas City,

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.