

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-039175

FILED VS DEC 1 1959 9

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. 5175 Registrar's No. _____

ENDED

1. PLACE OF DEATH a. COUNTY <u>Cedar</u> <u>Camden</u> <u>Russell</u> <u>Township</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> by COUNTY <u>Greene</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>near Mack's Creek</u> Length of stay in 1b <u>week-ends</u>		c. CITY OR TOWN <u>Springfield</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>vacation cabin</u>		d. STREET ADDRESS (If outside, give location) <u>733 N. National</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Owille</u> Middle <u>J.</u> Last <u>Murphy</u>			4. DATE OF DEATH Month <u>November</u> Day <u>1</u> Year <u>1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9-8-1902</u>	9. AGE (last birthday) <u>57</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during last 12 months, if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country)	
<u>Livestock Wr. Farmer</u>		<u>Farm</u>		<u>U.S.A.</u>	

13a. FATHER'S NAME <u>John Murphy</u>		13b. MOTHER'S MAIDEN NAME <u>Almeda C. Bristow</u>		14. NAME OF HUSBAND OR WIFE <u>Roxie Murphy</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>491-12-4555</u>		17. INFORMANT Address <u>Roxie Murphy - Springfield, Mo.</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Arteriosclerotic Coronary Arteries.</u>	
	DUE TO (c) _____	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION _____ COUNTY _____ STATE _____	

21. I attended the deceased from 21 April 1959 to Nov 1 1959 and last saw him alive on 1 Oct 1959
Death occurred at 7:00 a. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Aldred Eldred</u>		22b. ADDRESS <u>Springfield, Mo</u>		22c. DATE SIGNED <u>6/10/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11-3-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>East Lawn Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Springfield Missouri</u>	

24. FUNERAL DIRECTOR ADDRESS <u>Rex Rainey - Springfield, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Nov. 27 - 1959</u>		26. REGISTRAR'S SIGNATURE <u>Aldred Eldred</u>	
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

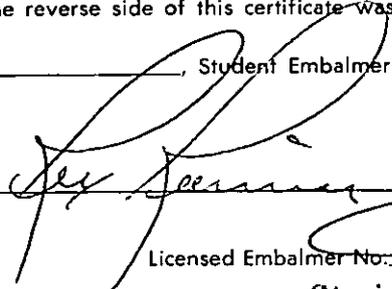
BY AFFIDAVIT OF

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 _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed 
Licensed Embalmer No. 3312

P. O. Address Springfield, Ill

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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