

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-006459

FILED VS MAR 11 1960

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1207 STATE FILE NUMBER

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | |
| a. COUNTY <u>Jackson</u> | b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u> | a. STATE <u>Missouri</u> | b. COUNTY <u>Jackson</u> |
| Length of stay in lb <u>14 years</u> | | c. CITY OR TOWN <u>Kansas City</u> | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St Lukes Hosp</u> | | d. STREET ADDRESS (If outside, give location) <u>5050 Oak</u> | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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|--|----------------------------------|--|---|---|--|
| 3. NAME OF DECEASED (Type or print) | | | 4. DATE OF DEATH | | |
| First <u>Catherine</u> | Middle <u>Murphy</u> | Last <u>Murphy</u> | Month <u>Feb</u> | Day <u>28</u> | Year <u>1960</u> |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>June 7, 1886</u> | 9. AGE (last birthday) <u>73</u> | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | 11. BIRTHPLACE (City and state or country) <u>Yonkers N.Y.</u> | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u> | |

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|--|---|--|
| 13a. FATHER'S NAME <u>William O'Connor</u> | 13b. MOTHER'S MAIDEN NAME <u>Johanna Ferry</u> | 14. NAME OF HUSBAND OR WIFE <u>Harry Murphy (Dec)</u> |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u> | 16. SOCIAL SECURITY NO. <u>None</u> | 17. INFORMANT <u>William P. Murphy</u> |
| | | Address <u>5050 Oak</u> |

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|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: | | |
| IMMEDIATE CAUSE (a) <u>Brain Tumor</u> | DUE TO (b) <u>Astrocystoma Grade IV</u> | |
| 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"/> N. <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 Dec 59 to death and last saw her/him alive on 2.28.60.
Death occurred at Saint Lukes Hosp. on the date stated above, and to the best of my knowledge, from the causes stated.

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|---|---|--|
| 22a. SIGNATURE (Degree or title) <u>F. Carmichael M.D.</u> | 22b. ADDRESS <u>Plaza Tower Bldg</u> | 22c. DATE SIGNED <u>28 Feb/60</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>Mar 1, 1960</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Calvary</u> |
| 24. FUNERAL DIRECTOR ADDRESS <u>Muehlebach 6800 Troost</u> | | 23d. LOCATION (City, town, or county) (State) <u>Kansas City Missouri</u> |
| 25. DATE RECD. BY LOCAL REG. <u>2.29.60</u> | 26. REGISTRAR'S SIGNATURE <u>Gene Minshall</u> | |

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF F. Carmichael

After 1:00 P.M. Mon

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed J. T. Crowell

Licensed Embalmer No. 490

P. O. Address K.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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.