

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-042816

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5796

FILED NOV 29 1962

VS 300 Rev. 4/59	AMENDED				
1	DATE AMENDED				
23188					
3					
4 1					
5 2					
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7 1					
8 2					
94200					
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1253-2					
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

SHOULD READ

BY AFFIDAVIT OF

William P. Adams MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u> Length of stay in lb <u>40 yrs.</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>Doctors Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>3439 East 7th St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>EMMA</u> Middle <u>MURPHY</u> Last <u>MURPHY</u>		4. DATE OF DEATH Month <u>November</u> Day <u>16</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cauc.</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>April 4-88</u>
9. AGE (last birthday) <u>74</u>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Church Housekeeper</u>	11. BIRTHPLACE (City and state or country) <u>Illinois</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13. FATHER'S NAME <u>John M. Clemens</u>	
14. MOTHER'S MAIDEN NAME <u>EMMA CURTIS</u>		15. NAME OF HUSBAND OR WIFE <u>William C. Murphy</u>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		17. SOCIAL SECURITY NO. <u>48</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), PART I. DEATH WAS CAUSED BY:		19. INFORMANT <u>Mrs. John M. Clemens</u> Address <u>St. Louis, MO.</u>	
IMMEDIATE CAUSE (a) <u>Broncho-pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>	
DUE TO (b) <u>Myocardial Decompensation and failure</u>		<u>6 wks.</u>	
DUE TO (c) <u>Arteriosclerotic Heart Disease</u>		<u>10 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Fibrosis and Arthritis</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
20. HYPERTENSION, Coronary and Aortic		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
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"/>	20c. TIME OF INJURY /Hour _____ /Month, Day, Year _____ p.m.	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input 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 <u>9/22/62</u> to <u>11/16/62</u> and last saw her/him alive on <u>11/16/62</u>		Death occurred at <u>5:40</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <u>William P. Adams, D.O.</u>		22b. ADDRESS <u>3221 Independence Ave., K.C., Mo.</u>	22c. DATE SIGNED <u>11/17/62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>11-19-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Burlington Iowa</u>
24. FUNERAL DIRECTOR <u>Muehlebach</u> ADDRESS <u>6800 Troost</u>		25. DATE RECD. BY LOCAL REG. <u>11-17-62</u>	26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>

USE BLACK INK OR TYPEWRITER RIBBON

Dr. Wm Adams 3221 Indep. Ave  
Ch 1-6081

after 2:00 PM.

**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

*R. E. Nichols*

Licensed Embalmer No. 7997

P. O. Address K. E. Ford

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.