

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-006855
STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 119 Primary Registration District No. 1002 Registrar's No. 954

FILED FEB 26 1963

VS 300	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	INSTEAD OF	DOCUMENT
Rev. 4/59				
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USE BLACK INK OR TYPEWRITER RIBBON		SHOULD READ	BY AFFIDAVIT OF	

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 1b 14 yrs.	c. CITY OR TOWN Kansas City
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Luke's Hospital		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 20 Janssen Place
3. NAME OF DECEASED (Type or print) First William Middle E. Last Murphy		4. DATE OF DEATH Month February Day 10 Year 1963	
5. SEX male	6. COLOR OR RACE cauc.	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3-9-1913
9. AGE (last birthday) 49		IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) owner		10b. KIND OF BUSINESS OR INDUSTRY rental property	11. BIRTHPLACE (City and state or country) Frankfurt, Indiana
12. CITIZEN OF WHAT COUNTRY U. S. A.		13a. FATHER'S NAME Daniel Murphy	
13b. MOTHER'S MAIDEN NAME Lelah Powers		14. NAME OF HUSBAND OR WIFE Ruth Murphy	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give yr or dates of service) yes W. W. II		16. SOCIAL SECURITY NO. -	17. INFORMANT Address Mrs. Ruth Murphy 20 Janssen Place
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) infarct of myocardium DUE TO (b) coronary arteriosclerosis DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 12 hrs.
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
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 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 1958 to Feb. 9 63 and last saw her alive on Feb. 9-63 Death occurred at 4:15A. m on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) Daniel J. Lauer M.D.	
22b. ADDRESS 4320 Wornall Rd.		22c. DATE SIGNED 2-11-63	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 2-12-63	23c. NAME OF CEMETERY OR CREMATORY Mt. Moriah	
23d. LOCATION (City, town, or county) Kansas City, Mo.		(State)	
24. FUNERAL DIRECTOR ADDRESS D. W. Newcomer's Sons 1331 Brush Creek		25. DATE RECD. BY LOCAL REG. 2-12-63	26. REGISTRAR'S SIGNATURE Ruth Long

OFFICE OF THE
COMMISSIONER OF HEALTH

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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. _____

P. O. Address _____

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.