

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

PLACE OF DEATH

County Green  
Township Clay  
or  
Village \_\_\_\_\_  
or  
City \_\_\_\_\_ (NO. \_\_\_\_\_ St.; \_\_\_\_\_ Ward)

Registration District No. 321 File No. 36768  
Primary Registration District No. 3244 Registered No. 257

(If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME Paul D. Murphy

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Male COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)

DATE OF DEATH Dec 3, 1915  
(Month) (Day) (Year)

DATE OF BIRTH Nov 22, 1915  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Nov 22, 1915, to Dec 3, 1915, that I last saw him alive on Dec 3, 1915, and that death occurred, on the date stated above, at 12 a.m.

AGE \_\_\_\_\_ If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?  
\_\_\_\_\_ yrs. \_\_\_\_\_ mos. 12 ds.

The CAUSE OF DEATH\* was as follows:  
Pneumonia

OCCUPATION (a) Trade, profession, or particular kind of work none  
(b) General nature of industry, business, or establishment in which employed (or employer) none

BIRTHPLACE (City or town, State or foreign country) Mentor Mo

109A  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 10 ds.

PARENTS  
NAME OF FATHER John B Murphy  
BIRTHPLACE OF FATHER (City or town, State or foreign country) Ozark Mo  
MAIDEN NAME OF MOTHER Ona Alma Gray  
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Mentor Mo

Contributory (SECONDARY) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) Dr J C Young M. D.  
Dec 3, 1915 (Address) Ozark Mo

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) N D Gray  
(ADDRESS) Ozark Mo

PLACE OF BURIAL OR REMOVAL Dodsantownery DATE OF BURIAL Dec 4, 1915

Filed Dec 15, 1915 W. L. Turner REGISTRAR

UNDERTAKER Ozark mere loo ADDRESS Ozark Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

# Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health  
Association]

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc. of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

*Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

**MISSOURI STATE BOARD OF HEALTH**  
**BUREAU OF VITAL STATISTICS**  
**CERTIFICATE OF DEATH**

REGISTRARS SHALL NOT RECEIVE  
 A FEE FOR CERTIFICATES UNTIL THEY  
 ARE COMPLETED AS PRESCRIBED BY  
 LAW

**1 PLACE OF DEATH**  
 County Green  
 Township Clay  
 or  
 Village \_\_\_\_\_  
 or  
 City \_\_\_\_\_

Registration District No. 321 File No. \_\_\_\_\_  
 Primary Registration District No. 5744 Registered No. 25  
 (NO. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a  
 hospital or institution,  
 give its NAME instead  
 of street and number.)

**2 FULL NAME** Paul D. Murphy

**PERSONAL AND STATISTICAL PARTICULARS**

<b>3 SEX</b>	<b>4 COLOR OR RACE</b>	<b>5 SINGLE MARRIED WIDOWED OR DIVORCED</b> (Write the word)
<u>M</u>	<u>W.</u>	<u>S</u>
<b>6 DATE OF BIRTH</b>		
_____ (Month) _____ (Day) 1 _____ (Year)		
<b>7 AGE</b>		<b>If LESS than 1 day, hrs. or min.?</b>
_____ yrs. _____ mos. _____ ds.		_____ or _____ min.?
<b>8 OCCUPATION</b>		
(a) Trade, profession, or particular kind of work _____ (b) General nature of industry, business, or establishment in which employed (or employer) _____		
<b>9 BIRTHPLACE</b> (City or town, State or foreign country)		
<b>PARENTS</b>	<b>10 NAME OF FATHER</b>	
	<b>11 BIRTHPLACE OF FATHER</b> (City or town, State or foreign country)	
	<b>12 MAIDEN NAME OF MOTHER</b>	
	<b>13 BIRTHPLACE OF MOTHER</b> (City or town, State or foreign country)	

**MEDICAL CERTIFICATE OF DEATH**

**16 DATE OF DEATH** Dec 3 1911  
 (Month) (Day) (Year)

**17 I HEREBY CERTIFY**, that I attended deceased from \_\_\_\_\_, 191\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_, and that death occurred on the date stated above, at \_\_\_\_\_.  
 The CAUSE OF DEATH\* was as follows:

**Supplied**  
**Supplied**  
**Supplied**

**Pneumonia**  
 (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 10 ds.

**CONTRIBUTORY** (Secondary)  
 (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 (Signed) H. J. C. Young M. D.  
 \_\_\_\_\_ 1911 (Address) Clark Mo.

**14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**  
 (Informant) \_\_\_\_\_  
 (Address) \_\_\_\_\_

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

**18 LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients, or Recent Residents)  
 At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 Where was disease contracted if not at place of death? \_\_\_\_\_  
 Former or usual residence \_\_\_\_\_

**15** Filed Dec 15 1911 by W. L. Turner Registrar

**19 PLACE OF BURIAL OR REMOVAL** \_\_\_\_\_ **DATE OF BURIAL** \_\_\_\_\_ 191\_\_\_\_  
**20 UNDERTAKER** \_\_\_\_\_ **ADDRESS** \_\_\_\_\_

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36768  
Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc. of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or inter-current) affection need not be stated unless important. Example: *Measles* (disease causing death), 29ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)