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

PLACE OF DEATH

County Putnam

Township Sherman
or
Village
or
City (No. St.: Ward)

Registration District No. 729 File No. 1 2623

Primary Registration District No. 5954 Registered No.

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

FULL NAME Emma Francis Murphy

PERSONAL AND STATISTICAL PARTICULARS

SEX Female

COLOR OR RACE White

~~SINGLE~~ MARRIED ~~WIDOWED~~ ~~OR DIVORCED~~ (Write the word)

DATE OF BIRTH [illegible] 11 (Month) 28 (Day) 1875 (Year)

AGE 41 yrs. 11 mos. 23 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE (City or town, State or foreign country) Putnam Co Mo

PARENTS

NAME OF FATHER John Wesley VanDyke

BIRTHPLACE OF FATHER (City or town, State or foreign country) Putnam Co Mo

MAIDEN NAME OF MOTHER Sarah Elizabeth Michelle

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Appanoose Ia

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. B. Murphy

(ADDRESS)

Filed 1/23, 1917. E. B. Thompson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan (Month) 22 (Day), 1917 (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 14, 1917, to Jan 22, 1917, that I last saw her alive on Jan 22, 1917, and that death occurred, on the date stated above, at 12 40 P.m.

The CAUSE OF DEATH* was as follows:

Puerperal Septicaemia

145/A 37

(Duration) ___ yrs. ___ mos. 9 ds.

Contributory (SECONDARY) Lagrippe

(Duration) ___ yrs. ___ mos. 5 ds.

(Signed) L. L. Gray M. D.

Jan 23, 1917 (Address) Powersville 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 State ___ yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL Union Church Cemetery

DATE OF BURIAL 1-24, 1917

UNDERTAKER D. W. Comstock

ADDRESS Unionville 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.

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

[illegible] IS A PERMANENT RECORD

Revised United States Standard Certificate of Death

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

"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 in-

PLACE OF DEATH

County.....

Township.....
or
Village.....
or
City.....(NO.....St.:.....Ward

MISSOURI STATE BO
BUREAU OF VITAL
CERTIFICATE OF

Registration District No.....File No.....

Primary Registration District No.....Registered No

FULL NAME.....

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH

.....(Month).....(Day), *1*.....(Year)

AGE

.....yrs.....mos.....ds.

If LESS than 1 day,.....hrs. or.....min.?

OCCUPATION
(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant).....

(ADDRESS).....

Filed.....191.....

REGISTRAR

MEDICAL CERTIFICATE OF

DATE OF DEATH

.....(Month)

I HEREBY CERTIFY, that I

.....191....., to.....

that I last saw h.....alive on.....

and that death occurred, on the date st

The CAUSE OF DEATH* was as follow

.....

.....

.....

.....(Duration).....yrs.

Contributory
(SECONDARY).....

.....(Duration).....yrs.

(Signed).....

.....191.....(Address).....

*State the Disease Causing Death, or, in death (1) Means of Injury; and (2) whether Accidental, Suicid

LENGTH OF RESIDENCE (FOR HOSPITALS, INS RECENT RESIDENTS)

At place of death.....yrs.....mos.....ds. In the State.....

Where was disease contracted if not at place of death?.....

Former or usual residence.....

PLACE OF BURIAL OR REMOVAL

UNDERTAKER