

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

PLACE OF DEATH

County Scott  
Township Morley  
or Morley  
Village Morley  
or  
City \_\_\_\_\_ (NO. \_\_\_\_\_ St.; \_\_\_\_\_ Ward)

Registration District No. 819 File No. 22147

Primary Registration District No. 4486 Registered No. 6

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

FULL NAME Alford 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 June 16, 1918  
(Month) (Day) (Year)

DATE OF BIRTH August - 23, 1886  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from June 14, 1918, to June 16, 1918, that I last saw him alive on June 16, 1918, and that death occurred, on the date stated above, at 1:30 P.M.

AGE 31 yrs. 9 mos. 23 ds.  
If LESS than 1 day, \_\_\_\_ hrs. or \_\_\_\_ min.?

The CAUSE OF DEATH\* was as follows:  
Typhoid fever of June 23  
106 D  
(Duration) 1 yrs. \_\_\_\_ mos. \_\_\_\_ ds.

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

Contributory Diphtheria  
(SECONDARY) (Duration) \_\_\_\_ yrs. 1 mos. \_\_\_\_ ds.

BIRTHPLACE (City or town, State or foreign country) Cape Co mo.

NAME OF FATHER Riley Murphy

(Signed) E. D. Harris M. D.  
June 16, 1918 (Address) Morley Mo

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

MAIDEN NAME OF MOTHER Elizabeth Duroc

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

\*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.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Where was disease contracted If not at place of death?

(Informant) A. B. Murphy

Former or usual residence

(ADDRESS) Morley Mo

PLACE OF BURIAL OR REMOVAL Morley Cem. DATE OF BURIAL June 17, 1918

Filed June 1918 Mrs. J. M. Froelich REGISTRAR

UNDERTAKER C. D. M. Guplon ADDRESS Morley Mo.

**PLACE OF DEATH**

County.....  
 Township.....  
 or  
 Village.....  
 or  
 City..... (NO. .... St. .... Ward)

Registration District No. .... File No. ....  
 Primary Registration District No. .... Registered No. ....

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

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

**FULL NAME**

**PERSONAL AND STATISTICAL PARTICULARS**

|               |                                |   |
|---------------|--------------------------------|---|
| SEX           | COLOR OR RACE                  | SINGLE<br>MARRIED<br>WIDOWED<br>OR DIVORCED<br>(Write the word) |
| DATE OF BIRTH | (Month) ....., 191..... (Year) | AGE   |
|               |                                | If LESS than 1 day, ....., hrs. or ....., min.?                 |
|               |                                | .....yrs. ....mos. ....ds.                                      |

**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).....

**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 DEATH**

**DATE OF DEATH**  
 ....., 191..... (Month) ....., 191..... (Year)

**I HEREBY CERTIFY, that I attended deceased from**  
 ....., 191....., to ....., 191.....  
 that I last saw h..... alive on ....., 191.....  
 and that death occurred, on the date stated above, at..... m.

**The CAUSE OF DEATH\* was as follows:**

**Contributory**  
 (SECONDARY)..... (Duration).....yrs. ....mos. ....ds.  
 (Signed)..... (Duration).....yrs. ....mos. ....ds. M. D.  
 191..... (Address)

\*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. State.....yrs. ....mos. ....ds.  
 Where was disease contracted if not at place of death?  
 Former or usual residence.....

**PLACE OF BURIAL OR REMOVAL**  
 DATE OF BURIAL..... 191.....

**UNDERTAKER**  
 ADDRESS.....

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

1. PLACE OF DEATH  
 County Scott Registration District No. 819 File No. ....  
 Township Murley Primary Registration District No. 4495 Registered No. 6  
 City Murley (No. ....) St. .... Ward .....

2. FULL NAME Alford Murphy  
 (a) Residence No. .... St. .... Ward .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

6. DATE OF BIRTH (MONTH, DAY AND YEAR) .....

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. ....

8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work? .....

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 16 1918

17. I HEREBY CERTIFY That I attended deceased from ..... 19..... to ..... 19..... that I last saw h. .... alive on ..... 19..... and that death occurred, on the date stated above, at .....

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds. ....

18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Murley Cem. DATE OF BURIAL June 17 1918

20. UNDERTAKER C. M. Gipton ADDRESS Murley Mo.

SUPPLEMENTARY INFORMATION SUPPLIED  
 INFORMATION SUPPLIED  
 SUPPLEMENTARY INFORMATION SUPPLIED  
 INFORMATION SUPPLIED

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) .....

10. NAME OF FATHER .....

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) .....

12. MAIDEN NAME OF MOTHER .....

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) .....

14. INFORMANT (Address) .....

15. FILED June 18 1918 Mrs. J. M. Tomlinson REGISTRAR

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

*Information by Mrs. Nell Tomlinson*

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED

# 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*, *Composer*, *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

2402  
"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," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "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.)

NOTE.—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death; Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.