AUG 22 1927

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

Do not use this space.

18997

1. PLACE OF DEATH
County: Ray Woodard
Township: Lafayette
City: (No. , St. Ward)

Registration District No. 604
Primary Registration District No. 5862 5944

File No. 364
Registered No. 364

2. FULL NAME: Roy 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: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Single

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF (OR) WIFE OF X

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Sept. 11, 1925

7. AGE: Years | Months: 21 months old | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): Y
(c) Name of employer

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

PARENTS
10. NAME OF FATHER: Roy Murphy
11. BIRTHPLACE OF FATHER (CITY OR TOWN): Ky.
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER: Nellie Bogarth
13. BIRTHPLACE OF MOTHER (CITY OR TOWN): Ky.
(STATE OR COUNTRY)

14. INFORMANT: Dr. Bogarth
(Address): Portageville Mo

15. FILED: 8/2, 1927 W. O. Bannon
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2

16. DATE OF DEATH (MONTH, DAY AND YEAR): June 10 1927

17. I HEREBY CERTIFY, That I attended deceased from June 8, 1927, to June 10, 1927, that I last saw him alive on June 10, 1927, and that death occurred, on the date stated above, at 11:00 AM

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Whooping Cough & Colitis
9
11:00 A
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY): Whooping Cough
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? At home, Mo
DID AN OPERATION PRECEDE DEATH? No. DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS? Typical symptoms
(Signed) F. M. Mayfield, M. D
, 19 (Address) Portageville Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: New Hope Cemetery
DATE OF BURIAL: 6-11 1927
UNDERTAKER: R M Payne
ADDRESS: Portageville

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.