

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

Do not use this space.

**27476**

**1. PLACE OF DEATH**

County Jackson Registration District No. 399 File No. 127  
 Township New Primary Registration District No. 1002 Registered No. 2-11  
 City Kansas City (No. St. Joseph Hospital) St.      Ward     

**2. FULL NAME**

(a) Residence No. 3409 Benton St.      Ward      (If nonresident give city or town and State)  
 (Usual place of abode)  
 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 Female 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     

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1-30-1865

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
62 8               

**8. OCCUPATION OF DECEASED**

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

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

10. NAME OF FATHER Dennis Murphy

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

12. MAIDEN NAME OF MOTHER Miss Sheehan

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

14. INFORMANT Alma Murphy (Address) Kansas City Mo.

15. FILED 10/3 27 m.m. Crowe REGISTRAR Asst

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9-30 1927

17. I HEREBY CERTIFY, That I attended deceased from 6 months, 1927, to     , 19    , that I last saw him alive on 9-30, 1927, and that death occurred, on the date stated above, at 12 m. approx.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

acute dilatation of heart 95B (duration) yrs. 4 mos.      ds.  
 CONTRIBUTORY Thyroid Ectoxine (SECONDARY) Thyroidectomy (duration) yrs.      mos.      ds.

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

1 DID AN OPERATION PRECEDE DEATH?      DATE OF     

WAS THERE AN AUTOPSY?     

WHAT TEST CONFIRMED DIAGNOSIS?     

(Signed) John O. Skinner M. D. (Address) 844 Lathrop

\*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 Kansas City Mo. DATE OF BURIAL 10-3 1927

20. UNDERTAKER J. P. Taylor ADDRESS Kansas City Mo.

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

WRITE PLAINLY, WITH UNFADING INK.

100-10000

100-10000

100-10000

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

ALL INFORMATION FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.  
 County Jackson Registration District No. 399  
 Township Taw Primary Registration District No. 1002  
 City (No. ....) St. .... Ward)

2. FULL NAME Jennie M. 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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S (write the word)

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

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

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 10/3 1937 M. M. Brown REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 20 1927

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

THE CAUSE OF DEATH WAS AS FOLLOWS:  
acute dilatation of heart

CONTRIBUTORY (SECONDARY) thyroid disease

18. WHERE WAS DISEASE CONTRACTED at home  
 IF NOT AT PLACE OF DEATH: .....

DID AN OPERATION PRECEDE DEATH? .....

WHAT TEST CONFIRMED DIAGNOSIS? Barium test  
 (Signed) John A. Kinross, M.D.  
 . 19..... (Address)

\*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 DATE OF BURIAL  
 19.....

20. UNDERTAKER ADDRESS

**SUPPLEMENTARY**

WRITE PLAIN INK UNFADING INK---THIS IS AN ANNUAL RECORD  
 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 COMPLETE AS PRESCRIBED BY LAW

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