

MAY 29 1928

Dr Harris

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

Do not use this space.

12630

1. PLACE OF DEATH

County *Clack*
Township *Jackson*
City *Johanna* (No. *190*)

Registration District No. *190*
Primary Registration District No. *327C*

File No. _____
Registered No. *16*
St. _____ Ward _____

2. FULL NAME

(a) Residence No. _____ St. _____ Ward _____
(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. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <i>Female</i>	4. COLOR OR RACE <i>W.</i>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <i>Widowed</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED—HUSBAND OR (OR) WIFE OF <i>Dennis McDonnell</i>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <i>March 1847</i>		
7. AGE YEARS <i>81</i> MONTHS <i>1</i> DAYS <i>—</i> IF LESS than 1 day, hrs. or min.		
8. OCCUPATION OF DECEASED <i>At Home</i> (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) *County Caslo*
(STATE OR COUNTRY) *Ireland.*

10. NAME OF FATHER *Michael Murphy*

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

12. MAIDEN NAME OF MOTHER *Catherine Doyle*

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

14. INFORMANT *Dennis McE. Donnell*
(Address) *Kahoka Mo. R.R.*

15. FILED *4/6*, 19*28* *J. P. Burgess*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *April 4 1928*

17. I HEREBY CERTIFY That I attended deceased from *Mias. 16*, 19*28*, to *Apr. 4*, 19*28*, that I last saw *h. a. a.* alive on *Apr. 4*, 19*28*, and that death occurred, on the date stated above, at *4:15 P.M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Valvular disease of heart

CONTRIBUTORY (SECONDARY) *90W*
(duration) yrs. mos. ds.

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

19. DID AN OPERATION PRECEDE DEATH? *No* DATE OF _____

20. WAS THERE AN AUTOPSY? *No*

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) *Ther. Harris*, M. D.
4/6, 19*28* (Address) *Clinton 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 *St Patrick Cem.* DATE OF BURIAL *4/7 1928*

20. UNDERTAKER *Fred Kalle* ADDRESS *Kahoka 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.

