

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

Do not use this space.

33976

4429

File No. _____
Registered No. _____
St. _____ Ward)

1. PLACE OF DEATH

County Jackson Registration District No. _____
Township Wm Primary Registration District No. _____
City Kansas City (No. K.C. Gen Hosp) _____

2. FULL NAME

Murphy, W.D.
(a) Residence. No. 2640 E 28th St. 11 Ward. _____
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 44 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 _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec. 17 - 1894

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>44</u>	<u>10</u>	<u>9</u>	

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Kansas City
(STATE OR COUNTRY) Mo.

10. NAME OF FATHER John Murphy
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ireland
(STATE OR COUNTRY) _____
12. MAIDEN NAME OF MOTHER Mrs. Helen
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ireland
(STATE OR COUNTRY) _____

14. INFORMANT Deputy Clerk
(Address) K.C. General Hosp

15. FILED 10/27 1929 M. M. Crowe
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10-26 1929

17. I HEREBY CERTIFY, That I attended deceased from 9-13 1929 to 10-26 1929 that I last saw him alive on 10-26 1929 and that death occurred, on the date stated above, at 12:10 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Tuberculosis of lungs

23A (duration) _____ yrs. _____ mos. _____ ds.

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

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

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Chest Lab Fund
(Signed) E. E. Williams, M.D.

10-26 1929 (Address) Subt K.C. Gen Hosp

*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. Mary cemetery DATE OF BURIAL 10-29-29
19

20. UNDERTAKER Ormont ADDRESS 115 E 15th

WRITE PLAINLY, WITH FADING INK---THIS IS A PERMANENT 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.

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