

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

Do not use this space.

43050

1. PLACE OF DEATH

113 County Worth
2 Township Shelbourn
2 City Grant City, Mo (No. 2)

Registration District No. 903

Primary Registration District No. 4670

File No. 30

Registered No. 30

St. _____ Ward _____

2. FULL NAME

(a) Residence. No. _____ St. _____ Ward _____

(Usual place of abode)

(If non-resident, 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

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Widowed

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

John Lovell

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

Feb 4-49

7. AGE

YEARS 83

MONTHS 9

DAYS 24

IF LESS than 1 day, _____ hrs. or _____ min.

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)

Penn
Illinois

10. NAME OF FATHER

Boles Murphy

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Yorktown
Illinois

12. MAIDEN NAME OF MOTHER

Widener

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Yorktown
Illinois

14.

INFORMANT

(Address)

Mrs O. Chamberling
Grant City, Mo

15.

FILED

12/15/32
John Andrews
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

Dec 28-1932

17.

I HEREBY CERTIFY, That I attended deceased from

Nov 15, 1932 to Dec 28, 1932

that I last saw her alive on Dec 27, 1932 and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

11 B Influenza

16a

(duration) _____ yrs. 1 mos. 14 ds.

CONTRIBUTORY (SECONDARY)

Senility

(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?

Clinical

(Signed) _____

J. A. Phipps, M. D.

Dec 28, 1932 (Address)

Grant City, 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

DATE OF BURIAL

Grant City Cemetery

12-29 1932

20. UNDERTAKER

ADDRESS

Andrews

Grant City, Mo.

WRITE PLAINLY, WITH UNFADING 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.

