BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1. PLACE OF DEATH
County: Nodaway
Township: Grant
City: (No. ..... St. ..... Ward)

Registration District No. 626
Primary Registration District No.

File No. 27184
Registered No.

2. FULL NAME: Sarah Malinda Murphin

(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: Female
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

5a. IF MARRIED, WIDOWED, OR DIVORCED
~~HUSBAND OF~~
(OR) WIFE OF: J. S. Murphin

6. DATE OF BIRTH (MONTH, DAY AND YEAR): June 24-1870

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
63	2	7	

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): Lincoln
(STATE OR COUNTRY): Nebr.

PARENTS
10. NAME OF FATHER: Geo. Sickels
11. BIRTHPLACE OF FATHER (CITY OR TOWN): ?
(STATE OR COUNTRY): Michigan
12. MAIDEN NAME OF MOTHER: Ellen Martin
13. BIRTHPLACE OF MOTHER (CITY OR TOWN):
(STATE OR COUNTRY): Iowa

14. INFORMANT: J. S. Murphin
(Address): Parnell Mo.

15. FILED: Sept 1 1933 Chas. Campbell REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Aug 31 1933

17. I HEREBY CERTIFY, That I attended deceased from Aug 28, 1933, to Aug 31, 1933, that I last saw her alive on Aug 31, 1933, and that death occurred, on the date stated above, at 1 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Hemorrhage
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY)
(duration) ..... yrs. ..... mos. 3 ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? at place of death
DID AN OPERATION PRECEDE DEATH? no DATE OF
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? inspection
(Signed) A. C. Long, M. D
, 19 (Address) Sheridan 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: Rose Hill Cem
DATE OF BURIAL: Sept 2 1933

20. UNDERTAKER: Newton Long
ADDRESS: Pawnee wood

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.

WHITE PAPER, WITH ONIONSKIN TRANSLUCENT RECORD IS A PERMANENT RECORD

SEP 26 1933

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

1. PLACE OF DEATH.

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No....., ...St. .....Ward)

2. FULL NAME .....

(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 | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*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)

PARENTS

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....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....
.....
.....
.....(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?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed).....,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

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.