

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.

JUN 4 1935

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

Do not use this space.

16607

1. PLACE OF DEATH
 County Jackson Registration District No. 399
 Township Lea Primary Registration District No. 1062
 City Kansas City (No. 511013) R. C. General Hospital #1 St. _____ Ward _____

2. FULL NAME Peter John 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 <u>M</u>	4. COLOR OR RACE <u>wh</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Catherine Murphy</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Sept. 17, 1907</u>		
7. AGE YEARS <u>27</u>	MONTHS <u>8</u>	DAYS <u>3</u>
If LESS than 1 day, _____ hrs or _____ min.		
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>day laborer</u>	
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.	
	10. Date deceased last worked at this occupation (month and year)	11. Total time (years) spent in this occupation
	12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Kansas City Mo</u>	
FATHER	13. NAME <u>Patrick John Murphy</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Texas</u>	
MOTHER	15. MAIDEN NAME <u>Noemie Rade</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Kansas City Mo</u>	
17. INFORMANT <u>Mrs. Catherine Murphy</u> (ADDRESS) <u>511013</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Forest Hill</u> DATE <u>May 23 1935</u>		
19. UNDERTAKER <u>J. N. O'Donnell Co</u> (ADDRESS) <u>R. C. Mo.</u>		
20. FILED <u>May 22 1935</u> <u>P. M. M. Brown</u> Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5/20/35 1935

22. I HEREBY CERTIFY That I attended deceased from _____ 19____
April 1935
 I last saw him alive on 24th 19____ Death is said to have occurred on the date stated above at _____ m.
 The principal cause of death and related causes of importance were as follows:
Acute Pulmonary Bronchitis
Right Hydro pneumothorax
 Date of onset _____

Other contributory causes of importance:
no

Name of operation _____ Date of _____
 What test confirmed diagnosis? Autopsy Was there an autopsy? yes

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased?
 If so, specify _____ (Signed) _____, M. D.
 (Address) _____

Dr. [unclear]

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County..... Registration District No..... File No.....
Township..... Primary Registration District No..... Registered No. *2119*
City..... (No. *General Hospital* St. Ward)

2. FULL NAME

Peter John 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

MEDICAL CERTIFICATE OF DEATH

3. SEX <i>Male</i>	4. COLOR OR RACE <i>Wh</i>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <i>Married</i>
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, .. his or .. min
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.	
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.	
	10. Date deceased last worked at this occupation (month and year)	11. Total time (years) spent in this occupation
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)		
FATHER	13. NAME	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)	
MOTHER	15. MAIDEN NAME	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)	
17. INFORMANT (ADDRESS)		
18. BURIAL, CREMATION, OR REMOVAL		
PLACE	DATE	
19. UNDERTAKER (ADDRESS)		
20. FILED <i>May 22 19 35 M. M. Crowe</i>		

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *5-20-1935*

22. I HEREBY CERTIFY, That I attended deceased from .., 19.., to .., 19..
I last saw him .. alive on .., 19.. Death is said to have occurred on the date stated above, at .. m.
The principal cause of death and related causes of importance were as follows:
Acute Purulent Bronchitis (Date of onset)
Hydropneumo thorax
Not tuberculous

Other contributory causes of importance:
110

Name of operation..... Date of ..
What test confirmed diagnosis? .. Was there an autopsy? ..

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? .. Date of injury .., 19..
Where did injury occur? .. (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....
Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? ..
If so, specify .. (Signed) .., M. D.
(Address) ..

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

RECEIVED
 MAY 22 1935
 MISSOURI STATE BOARD OF HEALTH

S-16607

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