

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

Do not use this space.

23305

AUG. 20 1935

**PLACE OF DEATH**

County Jackson  
Township Franklin  
City St. James

Registration District No. 399  
Primary Registration District No. 1002  
No. 557, Benton

File No. \_\_\_\_\_  
Registered No. 23305  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME** Lydia Jane Murphy  
(a) Residence, No. 557 Benton St., Benton Ward.

Length of residence in city or town where death occurred yrs. 6 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 <u>Female</u>	4. COLOR OR RACE <u>W.C.</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>widow</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>8-27-1861</u>		
7. AGE YEARS <u>73</u>	MONTHS <u>11</u>	DAYS <u>3</u>
If LESS than 1 day, _____ hrs. of _____ min.		
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>Housewife</u>		11. Total time (years) spent in this occupation _____
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) _____		
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Ohio</u>		
13. NAME <u>Oliver Sharp</u>		
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Ohio</u>		
15. MAIDEN NAME <u>Mary H. Lambert</u>		
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Ohio</u>		
17. INFORMANT <u>Mrs. J. F. Williams</u> (ADDRESS) <u>1982 Myrtle</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Edgar Park</u> DATE <u>7-19-35</u>		
19. UNDERTAKER <u>Mrs. R. D. Foster</u> (ADDRESS) <u>R. D. Mo</u>		
20. FILED <u>July 31</u> , 19 <u>35</u> <u>M. M. Corrows</u> Registrar.		

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July - 30, 19 35

22. I HEREBY CERTIFY That I attended deceased from July - 19 35 to July 30, 19 35  
I last saw her alive on July 30, 19 35 Death is said to have occurred on the date stated above, at 1055 P.M.  
The principal cause of death and related causes of importance were as follows:  
Cardio Failure Date of onset \_\_\_\_\_  
Terminal Pneumonia  
congenital Lower Right Lobe

Other contributory causes of importance \_\_\_\_\_  
Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ 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) Muriel O'Neil, M. D.  
(Address) 7134 Argyle R.C. 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.



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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS CERTIFICATE

3050

**1. PLACE OF DEATH**

County Jackson Registration District No. 399 File No. \_\_\_\_\_  
 Township \_\_\_\_\_ Primary Registration District No. 1002 Registered No. 3050  
 City Kansas, Mo (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Lydia Jensen Murphy  
 (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 F 4. COLOR OR RACE wh. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Wed

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.  
73 11 3

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 \_\_\_\_\_

19. UNDERTAKER (ADDRESS) \_\_\_\_\_

20. FILED 1/31 - 1935 M. M. Crowe Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 30, 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:

Cardiac Failure  
Fatty infiltration between muscle fibers of myocardium passive congestion liver, kidney, spleen  
 Date of onset \_\_\_\_\_

Other contributory causes of importance:

Terminal pneumonia  
Bronchitis

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) Myrtle O. Hill, M. D.

(Address) 734 Argyle St. C. 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.

AUG 31 1935

S-23305