

DEC'D FEB 20 1939

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

1345

Do not use this space.

358

1. PLACE OF DEATH

(a) County.....Jackson..... Registration District No.....1
 (b) Township.....Kaw..... Primary Registration District No.....
 (c) City.....Kansas City, Mo...... (d) Street No.....2516 Harrison, K.C.Mo...... St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Emma Josephine Murphy
 (a) Residence, No. 2516 Harrison Str., K.C.Mo. St.
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Widow</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>John Murphy</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Dec. 21st, 1865</u>		
7. AGE	YEARS <u>73</u>	MONTHS <u>1</u>
		DAYS <u>5</u>
		If LESS than 1 day, hrs. or min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.	
	9. Industry or business in which work was done, as saw mill, bank, etc. <u>At Home</u>	
	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>Missouri.</u>		
FATHER	13. NAME <u>John Miller,</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>No Record</u>	
MOTHER	15. MAIDEN NAME <u>No Record</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>No Record</u>	
17. INFORMANT <u>Fleta Fraser, 2516 Harrison</u> (ADDRESS) <u>Kansas City, Missouri.</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Green Lawn</u> DATE <u>Jan. 30</u> 19 <u>39</u>		
19. FUNERAL DIRECTOR (NAME) <u>Mrs. C.L. Forster</u> (ADDRESS) <u>918 Brooklyn Avenue, K.C.Mo.</u>		
20. FILED <u>Jan. 27, 1939</u> <u>M.M. Crowe pres.</u> Local Registrar.		

MEDICAL CERTIFICATE OF DEATH21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan. 26th, 1939

22. I HEREBY CERTIFY, That I attended deceased from Jan 14, 1939, to Jan 26, 1939
 I last saw her alive on Jan 20, 1939. Death is said to have occurred on the date stated above, at 11:45 P.M.
 The principal cause of death and related causes of importance were as follows:

Chronic endocarditis

Date of onset

1/23
Jan
1939

Other contributory causes of importance:

Arthritis

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? noIf so, specify E. A. Feilinger(Signed) E. A. Feilinger, M. D.(Address) 715 E. 19 Argyll BldgK.C. 190

Phone HA 4606

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.