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

REC'D MAY 10 1939

13752
Do not use this space.

1. PLACE OF DEATH
(a) County Jackson
(b) Township Kaw
(c) City K. C. Mo.
Registration District No. 399
Primary Registration District No. 1002
Registered No. 1506
(d) Street No. St. Mary's Hospital 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 (c/o) Harry J. Murphy
(a) Residence, No. 102 West Armour St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write the word*): Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Mrs. Agnes M. Murphy
6. DATE OF BIRTH (MONTH, DAY, AND YEAR): March 6, 1877
7. AGE: Years 62 | Months 1 | Days 1 | If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.: At Home
9. Industry or business in which work was done, as 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): Milwaukee, Wis.

FATHER
13. NAME: John P. Murphy
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Milwaukee, Wis.

MOTHER
15. MAIDEN NAME: Katherine Shea
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Milwaukee, Wis.

17. INFORMANT (ADDRESS): Mrs. Agnes M. Murphy, 102 West Armour

18. BURIAL, CREMATION, OR REMOVAL
PLACE Calvary DATE Apr. 10, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS): John W. Wagner, Kansas City, Mo.

20. FILED Apr 8, 1939 M. M. Crowe
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): April 7, 1939

22. I HEREBY CERTIFY, That I attended deceased from April 5, 1939, to April 7, 1939
I last saw him alive on April 7, 1939. Death is said to have occurred on the date stated above, at 9:30 a.m. am
The principal cause of death and related causes of importance were as follows:

	Date of onset
Cerebral hemorrhage	Apr 5 39

Other contributory causes of importance:
Arterial hypertension
Cerebral arteriosclerosis

Name of operation Date of
What test confirmed diagnosis? Clinical Was there an autopsy? No

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? No
If so, specify
(Signed) B. Landis Elliott, M. D.
(Address) 1636 Professional Bldg
B. LANDIS ELLIOTT.

(Licensed Embalmer's Statement on Reverse Side)

VI-7010

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 compl with the above constitutes grounds for revocation of license.)

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