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.

OCT 19 1939

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

33076
Do not use this space.

1. PLACE OF DEATH
(a) County New Madrid 2 Registration District No. 605
(b) Township Como 1 Primary Registration District No. 4359 Registered No.
(c) City Parma (d) Street No. 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 Cary F. Murphy
(a) Residence, No. 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 Female
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widow
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF William T Murphy
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 1875 - 12 - 11
7. AGE YEARS 63 MONTHS 9 DAYS 20 If LESS than 1 day, hrs. or min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. House Keeping
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) Tenn

FATHER
13. NAME Richard W Fowlkes
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn

MOTHER
15. MAIDEN NAME Fannie W Walker
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn

17. INFORMANT (ADDRESS) Dixie E Sullivan 802 Brooklyn Ave Sanatonia Tex
18. BURIAL, CREMATION, OR REMOVAL
PLACE Malden DATE 10-2 1939
19. FUNERAL DIRECTOR (NAME) (ADDRESS) J. C. Knight
20. FILED 10-2 1939 Dr Geo W Hustick
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) October -1- 1939
22. I HEREBY CERTIFY, That I attended deceased from Sept 27, 1939, to Oct 1, 1939
I last saw her alive on Oct 1, 1939. Death is said to have occurred on the date stated above, at 9 a.m.
The principal cause of death and related causes of importance were as follows:
Bronco-Phneumonia — Date of onset D.K.
107 N
Other contributory causes of importance: None
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) Edward Ford, M. D.
(Address) Parma, Mo.

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 2,
District File Number 1039-285
Date Filed 10-16

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, Thomas C Knight, or by

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

Signed Thomas C Knight

Licensed Embalmer No. 2189

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.