

Registration District No. 26

Primary Registration District No. 5370

Registrar's No. 87

1. PLACE OF DEATH:

(a) County Dent  
(b) City or town Rural Springcreek  
(c) Name of hospital or institution: -----  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME Rebecca Price Murphy

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F. 5. Color or race W. 6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife Thos Murphy 6. (c) Age of husband or wife if alive ? years  
7. Birth date of deceased Jan. 29 1862  
(Month) (Day) (Year)

8. AGE: Years 77 Months 9 Days 5 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Howard County Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
12. Name Andrew Collins  
13. Birthplace Missouri  
(City, town, or county) (State or foreign country)  
14. Maiden name Unknown  
15. Birthplace Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Beck J. J. J.  
(b) Address Sal em, Missouri  
17. (a) Removal (b) Date thereof 11/4/39  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Fulton, Missouri  
18. (a) Signature of funeral director Carl K. Spencer  
(b) Address Sal em, Missouri  
19. (a) November 4 1939 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dent  
(c) City or town Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 4  
year 1939 hour 3:25 minute \_\_\_\_\_ A. M.

21. I hereby certify that I attended the deceased from 10-12-39, 19\_\_\_\_, to 11-4-39, 19\_\_\_\_;  
that I last saw h. or alive on 11-2-39, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage Duration \_\_\_\_\_

Due to arteriosclerosis, hypertension

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(include pregnancy within 3 months of death)

Major findings: Of operations none  
Of autopsy none

PHYSICIAN  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature Jos. D. ... (M. D. or other) D.O.  
Address Sal em, Mo Date signed 11-4-39

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

**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.

**RECEIVED**

District Health Officer No. 5,

District File Number 1239480

Date Filed 121339

Signed Wm. W. McDonald

Licensed Embalmer No. 3806

P. O. Address Salem, Mo.

**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.**