

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

1487

State File No. 447  
Registrar's No.

Registration District No. 399

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas City Missouri  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
820 East 43rd Street  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 23 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
(c) City or town Kansas City Missouri  
(If outside city or town limits, write "RURAL")  
(d) Street No. 820 East 43rd Street (If rural, give location)  
(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME Mrs Katherine G. MURPHY

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Timothy M. Murphy 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased October 22, 1864-1866  
(Month) (Day) (Year)

8. AGE: Years 74-76 Months 3 Days 7 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Pottsville Penna  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife at home

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

12. Name P J Flynn

13. Birthplace UNKNOWN  
(City, town, or county) (State or foreign country)

14. Maiden name Anna Moran  
(City, town, or county) (State or foreign country)  
15. Birthplace Ireland  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Joseph Hyde  
(b) Address 3615 Wapping, K.C. Mo.

17. (a) Burial (b) Date thereof 2/1/41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Marys

18. (a) Signature of funeral director Mellody-McGilley

(b) Address Kansas City Missouri

19. (a) Jan 30 1941 (b) M. M. Crowe  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January, day 29th  
year 1941 hour eight minute 55 A.M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 1935, to 1-29, 1941;  
that I last saw her alive on 1-29, 1941;  
and that death occurred on the date and hour stated above.

Immediate cause of death Uremia

Due to Nephrosclerosis

Due to Generalized Arteriosclerosis

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

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 Superior Medical (M. D.)  
Address 736 Argyle Date signed 2-29-41

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

MOTHER FATHER

Duration 2 Wks

PHYSICIAN

Underline the cause to which death should be charged statistically.

**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 267

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

Signed J. H. Ryan

Licensed Embalmer No. 2929

P. O. Address CC

**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.**