

JAN 30 1943 / 49  
Registration District No. \_\_\_\_\_

Primary Registration District No. 1002

Registrar's No. 333

1. PLACE OF DEATH:  
(a) County Jackson  
(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
K. C. Gen. Hosp. No. 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 day  
In this community 45 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Henry Murphy  
3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced single  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years (Month) (Day) (Year)

7. Birth date of deceased June 29 1897  
(Month) (Day) (Year)

8. AGE: Years about 45 Months 6 Days 22 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation none

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

12. Name unknown  
13. Birthplace unknown  
(City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant Record Clerk  
(b) Address K. C. Gen. Hosp.

17. (a) Remove (b) Date thereof 1/23/43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Kirkville College of Pathology  
18. (a) Signature of funeral director Tom - Marshall  
(b) Address 2319 - Linwood  
19. (a) 1/22/43 (b) M. H. Brown  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: 48  
(a) State Missouri (b) County Jackson  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 118 1/2 Independence Avenue  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Jan. 21st  
year 1943 hour 6 minute 20 A.M.

21. I hereby certify that I attended the deceased from 1-20-43 19\_\_\_\_ to 1-21-43 19\_\_\_\_;  
that I last saw him alive on 1-21-43 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Broncho Pneumonia  
Duration \_\_\_\_\_

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

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

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

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) Means of injury \_\_\_\_\_

23. Signature Dr. R. Thoms (M. D. or other) \_\_\_\_\_  
Address Med. Dir. K. C. General Hosp. Date signed \_\_\_\_\_

MAKING BACK INK - MAKE A PERMANENT RECORD

MOTHER FATHER

**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:.....

*Ray E Snow*

Licensed Embalmer No. *2560*

P. O. Address..... *190 W*

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

**If this body is not embalmed, fact should be so stated above.**