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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED MAR 12 1943**  
Registration District No. 208

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

6954

State File No. ....

Primary Registration District No. 2725-

Registrar's No. 19

1. PLACE OF DEATH  
(a) County Macon  
(b) City or town Rural Hudson Mo  
(c) Name of hospital or institution: County Infirmary 5  
(d) Length of stay: In hospital or institution.....  
In this community.....  
years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo. (b) County Macon  
(c) City or town.....  
(d) Street No.....  
(e) Citizen of foreign country?.....  
If yes, name country.....

3. (a) PRINT FULL NAME James Murphy  
3. (b) If veteran name war..... 3. (c) Social Security No.....

4. Sex Male 5. Color or Race W 6. (a) Single, widowed, married, divorced.....  
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years  
7. Birth date of deceased.....

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Feb day 12 year 43 hour..... minute..... M.  
21. I hereby certify that I attended the deceased from Feb 10 1943 to Feb 12 1943  
that I last saw him..... alive on..... and that death occurred on the date and hour stated above.

Immediate cause of death.....  
Due to.....  
Due to.....  
Other conditions.....  
Major findings:  
Of operations.....  
Of autopsy.....

8. AGE: Years Months Days If less than one day  
DK hr. min.

9. Birthplace.....  
10. Usual occupation.....

11. Industry or business.....  
12. Name.....  
13. Birthplace.....  
14. Maiden name.....  
15. Birthplace.....

16. (a) Informant.....  
(b) Address.....  
17. (a) Burial, cremation, or removal..... (b) Date thereof.....  
(c) Place, burial or cremation.....

18. (a) Signature of funeral director.....  
(b) Address.....  
19. (a) Date received local registrar..... (b) Signature.....

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?.....  
(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 J F Turner M. D. or other:.....  
Address Macon Mo Date signed 3/13/43

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

MOTHER FATHER

RECEIVED

District Health Officer No. 10

District File Number 3-43543

Date Filed MAR 11 1953

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. 3057

P.O. Address Macon, 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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 695-4

Registration District No. ....

Primary Registration District No. 5725

Registrar's No. ....

1. PLACE OF DEATH:

(a) County Macon  
(b) City or town Rural  
(If outside city or town limits, write "RURAL" and name of township)  
(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..... (Specify whether  
years, months or days)

3. (a) PRINT FULL NAME

James Murphy

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

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced.....

6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day..... min.

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

10. Usual occupation

11. Industry or business

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

16. (a) Informant.....  
(b) Address.....

17. (a) (Burial, cremation, or removal) (b) Date thereof..... (Month) (Day) (Year)  
(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....  
(b) Address.....

19. (a) (Date received local registrar) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Macon  
(c) City or town Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No..... (If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 19 year 1943 hour ..... minute ..... M.  
21. I hereby certify that I attended the deceased from....., 19.....; that I per saw h..... alive on....., 19.....; and that death occurred on the date and hour stated above.

Immediate cause of death..... 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)  
(b) Did injury occur in or about home, on farm, in industrial place, in public place?  
While at work?..... (Specify type of place) (c) Means of injury.....

23. Signature..... (M. D. or other)  
Address..... Date signed.....

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

SUPPLEMENTARY

6954