

S. No. 2
DM-2-43
5-17-39
X35697

DEPARTMENT OF COMMERCE
BUREAU OF VITAL STATISTICS
FILED MAY 6 1943

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

13331

State File No. _____
Registrar's No. **1985**

Registration District No. 149

Primary Registration District No. 1002

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

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:
3044 Grand Avenue
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 35 years
In this community 35 years
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Lydia Turner Murphy
(b) If veteran, name war No
(c) Social Security No. None

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife James S.
6. (c) Age of husband or wife if alive 74 years
7. Birth date of deceased April 5, 1883
(Month) (Day) (Year)

8. AGE: Years 50 Months 6 Days 19
If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER {
12. Name Isaac Turner
13. Birthplace No Record
(City, town, or county) (State or foreign country)
14. Maiden name No Record
15. Birthplace No Record
(City, town, or county) (State or foreign country)

16. (a) Informant James Murphy Jr.
(b) Address 1617 East 31st St

17. (a) Burial (b) Date thereof 4-27-1943
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation St. Mary's Cemetery

18. (a) Signature of funeral director Quirk and Pabian
(b) Address 20 West Linwood

19. (a) Apr. 26 1943 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 1617 East 31st Street
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Apr day 24
year 1943 hour _____ minute 7 M.
21. I hereby certify that I attended the deceased from Feb 15
1943 to Apr 24 1943
that I last saw him alive on Apr 23 1943
and that death occurred on the date and hour stated above.
Immediate cause of death Myelogenous Leukemia & M.D.

Due to Leukemia & Anemia 2 M.D.

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy _____
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 A. J. Hoffman (M. D. or other) _____
Address 1617 East 31st St

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.....

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, fact should be so stated above.