

FILED AUG 21 1943

Registration District No. 149

Primary Registration District No. 1002

Registrar's No.

1. PLACE OF DEATH: Jackson

(a) County: Kansas City Mo

(b) City or town: (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 3916 Harrison Home 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: Home 2 mos
(Specify whether years, months or days)

In this community 45 Years
(years, months or days)

2. USUAL RESIDENCE OF DECEASED: Missouri Jackson 48

(a) State: Missouri (b) County: Jackson 3

(c) City or town: Kansas City Mo 8
(If outside city or town limits, write "RURAL")

(d) Street No: 3916 Harrison
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country: no 1

3. (a) PRINT FULL NAME: Ida M. Murphy

3. (b) If veteran, name war: no

3. (c) Social Security No: no

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 9th
year 1943 hour I AM minute M.

4. Sex: fe 5. Color or race: wh

6. (a) Single, widowed, married, divorced: 2 Widowed

6. (b) Name of husband or wife: Widow of Wm E. Murphy

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

7. Birth date of deceased: Feb 3 1865
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 6-11-43 19 to 8-9 19 23
that I last saw h. Eq alive on 8-8-19 43
and that death occurred on the date and hour stated above.

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

78 6 6 hr. min.

Immediate cause of death: Cerebral Embolus 2-MIC

9. Birthplace: Illinois (County) Home (State or foreign country)

Due to: 835

10. Usual occupation: Home

Other conditions (Include pregnancy within 3 months of death)

11. Industry or business: William Pickard

Major findings: Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

12. Name: William Pickard

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

14. Maiden name: Unknown

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

16. (a) Informant: Ben Moeling

(b) Address: 3916 Harrison

17. (a) Burial, cremation, or removal: Burial (b) Date thereof: Aug-11-43 (Month) (Day) (Year)

(c) Place: burial or cremation: Memorial Park Cem

18. (a) Signature of funeral director: Eyer Funeral Home

(b) Address: 1800 Linwood Blvd

19. (a) Date received local registrar: 8-10-43 (b) Registrar's signature: Dep. T. E. Brown

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: J. E. Ball (M. D. or other)

Address: 1102 E 47 Date signed: 8-23-43

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

Dr J.E.Ball Troost Centre Bg
Phone 103102
Home 4917 College
Phone WA 1993

4917 A Troost

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 Chas E. Wilks
Licensed Embalmer No. 2644
P. O. Address 1800 Pinewood

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.