

FILED NOV 9 1943  
Registration District No. **12**

Primary Registration District No. **1000**

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

1. PLACE OF DEATH:

(a) County Buchanan

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

(c) Name of hospital or institution:  
St. Joseph's Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 days  
(Specify whether years, months or days)

In this community 50 years,

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan

(c) City or town St. Joseph  
(If outside city or town limits, write "RURAL")

(d) Street No. 2710 Sacramento  
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)  
If yes, name country 0

3. (a) PRINT FULL NAME WILLIAM A. MURPHY

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

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

6. (b) Name of husband or wife Alice M. Murphy 6. (c) Age of husband or wife if alive 72 years

7. Birth date of deceased May 6th. 1870  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>73</u>	<u>5</u>	<u>10</u>	<u>hr. min.</u>

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

10. Usual occupation Engineer,

11. Industry or business Railroad,

12. Name James Murphy,

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

14. Maiden name Deborah Keating,

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

16. (a) Informant Mrs. Alice M. Murphy

(b) Address 2710 Sacramento, St. Joseph, Mo.

17. (a) burial (b) Date thereof 10/19/43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Olivet Cemetery,

18. (a) Signature of funeral director Robert Bowman

(b) Address 319 South 10th St. St. Joseph, Mo.

19. (a) 10/16/43 (b) Rose Herzog  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 16  
year 1943 hour 12 minute 55 A. M.

21. I hereby certify that I attended the deceased from Oct 10 19 43 to Oct 16 19 43 and that death occurred on the date and hour stated above.

Immediate cause of death Arterio-sclerosis, cerebral thrombosis

Due to Arterio-sclerosis

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

Other conditions 97  
(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)

23. Signature Dr. Joseph M. D. (M. D. or other) M.D.

Address St. Joseph, Mo. Date signed 10-16-43

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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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. Thomas

Licensed Embalmer No. 2640

P. O. Address St Joseph 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.**