

FILED JAN 12 1944

State File No.
Registrar's No. 1520

Registration District No.

Primary Registration District No. 1000

1. PLACE OF DEATH:

(a) County: Buchanan
(b) City or town: St. Joseph
(c) Name of hospital or institution: State Hospital # 2, 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 wks
In this community Same (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo. (b) County: Daviess
(c) City or town: Fultonburg
(If outside city or town limits write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country: 0

3. (a) PRINT FULL NAME: Dorothy-LEE-Murphy.

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

4. Sex: F 5. Color or race: W
6. (a) Single, widowed, married, divorced: Single
6. (b) Name of husband or wife: ... 6. (c) Age of husband or wife if alive: ... years

7. Birth date of deceased: June 22 1918
(Month) (Day) (Year)

8. AGE: Years 25 Months 11 Days 7 If less than one day hr. min.

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

10. Usual occupation: At Home

11. Industry or business: ...

12. Name: James Franklin Murphy.
13. Birthplace: Missouri (City, town, or county) (State or foreign country)

14. Maiden name: Effie M. Meade.
15. Birthplace: Fultonburg Mo. (City, town, or county) (State or foreign country)

16. (a) Informant: Parents
(b) Address: State Hospital

17. (a) R. (b) Date thereof: 12-29-43
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation: Fultonburg Mo.

18. (a) Signature of funeral director: ...
(b) Address: Fultonburg Mo.
19. (a) 12-29-43 (b) ... Registrar's signature

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 29 year 1943 hour 8 15 minute P M.
21. I hereby certify that I attended the deceased from June 11 1942 to 12/29/43 19...; that I last saw her alive on 12/29/43 19...; and that death occurred on the date and hour stated above.

Immediate cause of death: Meningo-encephalitis Syphilitic
Due to: ...
Due to: ...
Other conditions: Psychotic -
(Include pregnancy within 6 months of death)

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

Major findings: Of operations: ...
Of autopsy: ...

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify): No
(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?

23. Signature: ... (M. D. or other) ...
Address: State Hospital # 2 St. Joseph Mo. Date signed: 12/29/43

1255 (Licensed Embalmer's Statement on Reverse Side) St. Joseph Mo

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

MOTHER FATHER

JAN 18 1944

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.