

FILED DEC 11 1944

Registration District No. 144

Primary Registration District No. 5711

Registrar's No. _____

1. PLACE OF DEATH:

(a) County McDona'd
(b) City or town Burra
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Stella MO, R.F.D. # 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 60 Yrs.
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County McDona'd
(c) City or town Burra
(If outside city or town limits, write "RURAL")
(d) Street No. Stella MO, R.F.D. # 1
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 27
year 1944 hour 5 minute 30, P. M.

21. I hereby certify that I attended the deceased from
Nov. 1, 1944 to Oct. 27, 1944
that I last saw him alive on Oct. 26, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death
myocardial & aortic
regurgitations

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

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?

(Specify type of place)
While at work? _____ (e) Means of injury _____
23. Signature J. E. Williams (M. D. or other)
Address Burra MO Date signed 11/27/44

3. (a) PRINT FULL NAME ROBERT LEE MURPHY

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

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

7. Birth date of deceased Sept 17th, 1870
(Month) (Day) (Year)

8. AGE: Years 72 Months I Days IO
If less than one day hr. _____ min. _____

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

10. Usual occupation Farming

11. Industry or business _____

12. Name John Murphy

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

14. Maiden name Martha Tate

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

16. (a) Informant Georgia Murphy

(b) Address Stella Ho.

17. (a) Burra (b) Date thereof IO-29-1944
(Burial, cremation, or removal) (Month) (Day) (Year)
Rockycomfort MO.

(c) Place: burial or cremation _____

18. (a) Signature of funeral director Chas. Williams

(b) Address Goodman MO

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

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

MOTHER FATHER

Duration
about 1 yr.
PHYSICIAN
Underline the cause to which death should be charged statistically.

13507

DEC 28 1947

RECEIVED DEC 7 1947
District Health Officer No. _____
District File Number 1144 - 246
Date Filed DEC 7 1947

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 *Marcellene Williams Pickett*
Licensed Embalmer No. *4166*
P. O. Address *Losman, Md.*

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. See

Registration District No. 194

Primary Registration District No. 5711

Registrar's No. _____

1. PLACE OF DEATH:

(a) County McDonald
(b) City or town Rural Elk Horn Twp
(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 _____ (years, months or days)

3. (a) PRINT FULL NAME Robert Lee 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 M

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

7. Birth date of deceased Sept (Month) 1 (Day) 1944 (Year)

8. AGE: Years 29 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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

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

19. (a) Dec 14 1944 (b) D. E. Plimlee
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (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 CERTIFICATE

20. DATE OF DEATH: Month Dec year 1944 minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____ that last saw him alive on _____, 19____ and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____ (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) (e) Means of injury _____

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

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

38283