

FILED JAN 13 1947

Registration District No. 71

Primary Registration District No. 3012

Registrar's No. 170

1. PLACE OF DEATH:

(a) County Clay

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

(c) Name of hospital or institution: Veterans Administration Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 months 18 days  
(Specify whether years, months or days)

In this community 3 months 18 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Oklahoma (b) County --

(c) City or town Twin Oaks  
(If outside city or town limits, write "RURAL")

(d) Street No. (Gen. Del.)  
(If rural, give location)

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

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Aziel E. Murphy

3. (b) If veteran, name war WW I & WW II

3. (c) Social Security No. 487 12 2184

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 18  
year 1946 hour 11: 20 minute A. M.

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced Divorced

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased March 24 1898  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from August 30 1946 to December 18 1946  
that I last saw him alive on December 18 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death Tuberculosis, pulmonary, chronic, far advanced, active.

8. AGE:	Years	Months	Days	If less than one day
	<u>48</u>	<u>8</u>	<u>24</u>	hr. _____ min. _____

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

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

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

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

10. Usual occupation Cook

Major findings:  
Of operations \_\_\_\_\_

Of autopsy Same as above and tuberculous enteritis.

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name John Thomas Murphy

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

14. Maiden name Hannah Hutchinson

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

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? \_\_\_\_\_

16. (a) Informant Hospital records, Veterans Administration Hospital

(b) Address Excelsior Springs, Missouri

17. (a) Removal (b) Date thereof 12-18-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: removed to Galena, Ks.

(Specify type of place) \_\_\_\_\_

While at work? \_\_\_\_\_ (c) Means of injury 0 --- (1)

18. (a) Signature of funeral director HOPE FUNERAL HOME

(b) Address Excelsior Springs, Mo.

19. (a) 12-20-46 (b) Baralene Hutchinson  
(Date received local registrar) (Registrar's signature)

23. Signature [Signature] (M. D. or other) M. D.

Address Veterans Administration Hospital, Excelsior Springs, Mo. Date signed 12-18-46

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

RECEIVED

District Health Officer No. 8,

District File Number \_\_\_\_\_

Date Filed 1-11-77

**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 V. Hope

Licensed Embalmer No. 3950

P. O. Address Excelsior Springs

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.