

Registration District No. 316

Primary Registration District No. 3060

Registrar's No. 108

1. PLACE OF DEATH:
 (a) County St Francois
 (b) City or town Farmington, Mo.
(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 Twenty years (Specify whether years, months or days)
 In this community Twenty years

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo. (b) County St. Francois
 (c) City or town Farmington, (If outside city or town limits, write "RURAL")
 (d) Street No. 410 Franklin (If rural, give location)
 (e) Citizen of foreign country? No. (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Harriot Annise 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 W. 2
 6. (b) Name of husband or wife Alfred Murphy 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Oct. 11 1875
(Month) (Day) (Year)

8. AGE: Years 71 Months 5 Days 19 If less than one day hr. _____ min. _____

9. Birthplace Ste Genevieve, Mo. (City, town, or county) (State or foreign country)

10. Usual occupation Home Maker

11. Industry or business _____

MOTHER FATHER
 12. Name Robert Babb
 13. Birthplace Knorrville Tenn.
 14. Maiden name Mary Ellen Mackley
 15. Birthplace Mo.

16. (a) Informant Etta Murphy
 (b) Address Farmington, Mo.

17. (a) B. (b) Date thereof 4-4-1947
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Park View Cem.

18. (a) Signature of funeral director Cozean Funeral Home
 (b) Address Farmington, Mo.

19. (a) 4-2-47 (b) Cather Rudloff
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month April day 2 year 1947 hour 1 minute 8 M.

21. I hereby certify that I attended the deceased from March 21, 1947, to April 2, 1947, that I last saw her alive on March 21, 1947, and that death occurred on the date and hour stated above.

Immediate cause of death cerebral apoplexy (hemorrhage)
 Due to Hypertensive Cardiovascular disease
 Due to _____

Other conditions 93D
(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 _____
 Signature Ed Langhorne (M. D. or other) Med.
 Address Farmington, Mo. Date signed 4-2-47

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

RECEIVED

District Health Officer No. 4

District File Number 447-483

Date filed 4-7-47

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. 4084

P. O. Address Farmington 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.

APR 27 1947