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BUREAU OF THE CENSUS
FILED JAN 2 1948

Registration District No. **47**

Primary Registration District No. **3008**

Registrar's No. **435**

1. PLACE OF DEATH:

(a) County Calloway

(b) City or town Fulton

(c) Name of hospital or institution State Hospital No 1
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution 4 mo 15 days
(Specify whether (If not in hospital or institution, write street number or location))

In this community yes
years, months or days

3. (a) PRINT FULL NAME LILLIE MURPHY

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex f

5. Color or race white

6. (a) Single, widowed, married, divorced w 2

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Aug 7 1868
(Month) (Day) (Year)

8. AGE: Years 79 Months 4 Days 9

If less than one day hr. _____ min. _____

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

10. Usual occupation housewife

11. Industry or business _____

MOTHER FATHER

12. Name DR

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 Records State Hosp No 1

(b) Address Fulton Mo

17. (a) Removal (b) Date thereof Dec 17 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Junction City, Kans

18. (a) Signature of funeral director Glen W. Magerin

(b) Address 712 Camp Fulton, Mo

19. (a) 12-17-1947 (b) Jesse Moraskoff
(Date received local registrar) (Registrator's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson

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

(d) Street No. 4129 Mount
(If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 16
year 1947 hour 10 minute 53 a. M.

21. I hereby certify that I attended the deceased from Dec 12, 1947, to Dec 16, 1947
that I last saw her alive on Dec 16, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Septicemia with Embolic Pneumonia

Due to _____

Due to _____

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

PHYSICIAN

Major findings: _____

Of operations _____

Of autopsy _____

Underline the cause to which death should be charged statistically.

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 P.P. Price (M. D. or other) ml
Address Fulton Date 12/16/47

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

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed 12/31/47

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.....

Theodore Skinner, Jr., Registered Apprentice No. *3-5*
working under my personal supervision.

Signed *Glen Y. Mauhin*

Licensed Embalmer No. *3725*

P. O. Address *Fulton, 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.

Registration District No. *47*Primary Registration District No. *3008*Registrar's No. *400-*

1. PLACE OF DEATH:

(a) County *Callaway*
 (b) City or town *Fulton*
 (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

Lillie 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 *wid*

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

7. Birth date of deceased *Aug 7 1897*
(Month) (Day) (Year)8. AGE: Years *29* Months *30* Days *29* If less than one day _____ hr. _____ min.9. Birthplace *Sumner City Kansas*
(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 _____ (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (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 CERTIFICATION

20. DATE OF DEATH: Month *Mar* 19 *1925* year hour _____ minute _____ M.

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

Duration _____

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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 _____

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

MOTHER FATHER

SUPPLEMENTARY

41054