

FILED FEB 16 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

5132

State File No. ....

BIRTH NO. ....		REG. DIST. NO. <u>146</u>		PRIMARY REG. DIST. NO. <u>5368</u>		Registrar's No. <u>46</u>	
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).			
a. COUNTY Jackson		b. CITY (If outside corporate limits, write RURAL and give township) Kansas City		a. STATE Mo		b. COUNTY Jackson	
c. LENGTH OF STAY (in this place) 44 yrs		c. CITY (If outside corporate limits, write RURAL and give township) Kansas City		d. STREET ADDRESS 135 So Oxford, Intercity		e. CITY (If outside corporate limits, write RURAL and give township) Rural Blue	
d. FULL NAME OF HOSPITAL OR INSTITUTION 135 So Oxford				d. STREET ADDRESS (If rural, give location) 135 So Oxford, Intercity			
3. NAME OF DECEASED (Type or Print) JERRY		a. (First) P		b. (Middle) MURPHY		c. (Last)	
4. DATE OF DEATH (Month) (Day) (Year) 2/4/50		5. SEX Male		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Wid.	
8. DATE OF BIRTH 4/5/1874		9. AGE (In years last birthday) 75		10. IF UNDER 1 YEAR 9 Months		11. IF UNDER 14 HRS. 29 Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Switchman MOP Ry		11. BIRTHPLACE (State or foreign country) Franklin Co., New York		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Jerry Murphy		13b. MOTHER'S MAIDEN NAME Margaret Morrissey		14. NAME OF HUSBAND OR WIFE Annie Elizabeth Compion			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. no		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. C J Duggins, 135 So Oxford			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Arteriosclerotic Heart Disease</u>		DUE TO (b) <u>Arteriosclerosis, generalized</u>				12 yrs	
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		DUE TO (c) <u>Hematomyelia, 7th dorsal vertebra</u>				15 yrs	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		DUE TO (c) <u>Hematomyelia, 7th dorsal vertebra</u>				49 on	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>None</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>no injury</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>June</u> , 19 <u>48</u> , to <u>2-4-</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>2-4-</u> , 19 <u>50</u> , and that death occurred at <u>2:00 p.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Harold L. Bushe, M.D.</u>				23b. ADDRESS <u>1019 ARBYLE</u>		23c. DATE SIGNED <u>2-6-50</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>2/7/50</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet</u>		24d. LOCATION (City, town, or county) (State) <u>Kansas City, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>Feb 6-1950</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>Hohn Pl Sheil, K. C. Mo.</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

FEB 11 RECD

APR 12 1950

1019 ARGYLE Bldg.,  
Any time 2/6/50

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 \_\_\_\_\_

Student Embalmer No. 325

working under my personal supervision.

Student Gail L. Slack  
Student Embalmer

Signed John P. Sheil

Licensed Embalmer No. 3625

P. O. Address 156 2nd

\*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.