

FILED APR 26 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 13497

0804

BIRTH NO. _____		REG. DIST. NO. <u>274</u>		PRIMARY REG. DIST. NO. <u>3052</u>		Registrar's No. <u>139</u>	
1. PLACE OF DEATH a. COUNTY <u>Pettis</u>				2. USUAL RESIDENCE (Where deceased lived; If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Pettis</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Sedalia</u>		c. LENGTH OF STAY (in this place) <u>Life</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Sedalia</u>		<u>0804</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Bothwell Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>1503 East Broadway</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>JOHN</u>		b. (Middle) <u>DAVID</u>		c. (Last) <u>MURPHY</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April 16, 1951</u>	
5. SEX M <u>0</u>	6. COLOR OR RACE W <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Nov. 7, 1867</u>	9. AGE (In years last birthday) <u>83</u>		IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Locomotive Carpenter Rail Road</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Longwood, Missouri</u>		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME <u>Pryor F. Murphy</u>		13b. MOTHER'S MAIDEN NAME <u>Saline J. Glass</u>		14. NAME OF HUSBAND OR WIFE <u>Bettie Murphy</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Bettie Murphy, Sedalia, Mo</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Uremia.</u> ANTECEDENT CAUSES <u>Hypertensive Heart Disease</u> Morbid conditions, if any, giving rise to the above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Hypertrophy of the Prostate</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>2 years.</u> <u>5 years.</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>None. Medical treatment only.</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>None.</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		<u>443 X</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>None.</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>over 5 years</u> , 19 <u>51</u> , to <u>April 16th</u> 19 <u>51</u> , that I last saw the deceased alive on <u>April 16th, 1951</u> and that death occurred at <u>2:06 pm.</u> from the causes and on the date stated above.							
23a. SIGNATURE <u>Jno. B. Carlisle, M.D.</u>				23b. ADDRESS <u>Sedalia, Missouri.</u>		23c. DATE SIGNED <u>4-17-51</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>4-18-1951</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Crown Hill</u>		24d. LOCATION (City, town, or county) (State) <u>Sedalia, Missouri</u>	
DATE REC'D BY LOCAL REG. <u>4-18-1951</u>		REGISTRAR'S SIGNATURE <u>A. J. Campbell</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Schacht</u>		ADDRESS <u>Sedalia, Mo</u>	

GILLESPIE FUNERAL HOME

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

RECEIVED 4-25-51
DISTRICT HEALTH OFFICE No. 3
District File Number _____
Date Filed 4-25-51

APR 26 1951

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 _____

working under my personal supervision.

D. W. HECKART
GILLESPIE FUNERAL HOME
SEDALIA, MISSOURI

Signed.....
Student Embalmer

Student Embalmer No.....

D. W. Heckart

Licensed Embalmer No. 3470

P. O. Address *Sedalia, 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.