

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED FEB 16 1953

128

2000

145

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Pack	
b. CITY (If outside corporate limits, write RURAL and give township) Springfield		c. LENGTH OF STAY (In this place)	
c. CITY (If outside corporate limits, write RURAL and give township) Bolivar		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION Burge Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) Sharon b. (Middle) Annette c. (Last) Murphy			4. DATE OF DEATH (Month) (Day) (Year) Feb 8, 1953		
5. SEX FEMALE	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married	8. DATE OF BIRTH Nov. 17, 1951	9. AGE (In years last birthday) 1 yr 3 mos	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) Missouri	
				12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13a. FATHER'S NAME Bobbie Darril Murphy		13b. MOTHER'S MAIDEN NAME Wanda Carol Hocken		14. NAME OF HUSBAND OR WIFE Wanda Murphy	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or date of service) No		16. SOCIAL SECURITY NO. No		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Wanda Murphy, Bolivar	

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, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Tuberculous meningitis		INTERVAL BETWEEN ONSET AND DEATH 1 wk
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Military Tuberculosis		
	DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION DIOX		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.)	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 **6-31, 1953** to **2-8, 1953** that I last saw the deceased alive on **2-8, 1953**, and that death occurred at **2:30 PM** from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Arthur B. ...		23b. ADDRESS Springfield, Mo		23c. DATE SIGNED 2-8-53
24a. BURIAL, CREMATION, REMOVAL (Specify) Removed	24b. DATE 2-8-1953	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) Bolivar, Mo	

DATE REC'D BY LOCAL REG. 2-10-53	REGISTRAR'S SIGNATURE Edith Williamson	25. GENERAL DIRECTOR'S SIGNATURE ADDRESS Erwin + Blue Bolivar, Mo
--	--	---

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

MISSOURI
DEPARTMENT OF HEALTH
DIVISION OF PUBLIC HEALTH

FEB 25 1953

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. _____

working under my personal supervision.

Student
Student Embalmer

Signed *Oby Jester*

Licensed Embalmer No. *H154*

P. O. Address *Bolivar, 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.