

FILED JUL 8 1957

STANDARD CERTIFICATE OF DEATH

State File No. **19930**

BIRTH NO. _____ REG. DIST. NO. 1 PRIMARY REG. DIST. NO. 5008 Registrar's No. 237

1. PLACE OF DEATH a. COUNTY Adair		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Sullivan	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural-Walnut Twp.		c. LENGTH OF STAY (In this place) 50 days	c. CITY OR TOWN _____
d. FULL NAME OF HOSPITAL OR INSTITUTION Route 3, Green Castle, Mo.		STREET ADDRESS (If rural, give location) No street address	

3. NAME OF DECEASED (Type or Print)	a. (First) Annie	b. (Middle) Florence	c. (Last) Murphy	4. DATE OF DEATH (Month) (Day) (Year) June 26 1957
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH March 28, 1874	9. AGE (In years less birthday) 83	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Farm home	11. BIRTHPLACE (City and State or Foreign Country) Green City, Missouri	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Henry Shaver	13b. MOTHER'S MAIDEN NAME Mary Frances Williams	14. NAME OF HUSBAND OR WIFE J. D. Murphy
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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. None	17. INFORMANT'S SIGNATURE OR NAME Ralph Murphy, Green Castle, Mo.	ADDRESS _____
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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) Medullary Failure		
	ANTECEDENT CAUSES Due to (b) Toxemia of uremia Due to (c) Renal Failure (Cardiovascular)		
II. OTHER SIGNIFICANT CONDITIONS Cancer of Breast with metastasis to vital organs			

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION to vital organs	20. AUTOPSY? Yes YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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) Green Castle, Sullivan, Mo.
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 5/8, 1957, to 6/26, 1957, that I last saw the deceased alive on 6/26, 1957, and that death occurred at 1:50 pm., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) R. H. Casner D.O.	23b. ADDRESS Green City, Mo.	23c. DATE SIGNED 6-28-57
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE June 29, 1957	24c. NAME OF CEMETERY OR CREMATORY Green City Cemetery	24d. LOCATION (City, town, or county) (State) Green City, Mo.
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DATE REC'D BY LOCAL REG. 7-2-57	REGISTRAR'S SIGNATURE Doris W. Rathoff	25. FUNERAL DIRECTOR'S SIGNATURE Allen E. Feltlow, Green City, Mo.	ADDRESS _____
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(Licensed Embalmer's Statement on Reverse Side)

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

5350

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.....
Signature of Student Embalmer

Signed..... *Carl R. Kent*.....

Licensed Embalmer No. *4687*

P. O. Address *Green City, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.