

THE DIVISION OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

35389

STATE FILE NUMBER

FILED NOV 12 1957

Registration District No. 120

Primary Registration District No. 5444

Registrar's No. 129

5. 300  
v. 1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <b>Gentry</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Gentry</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Albany, Athens, Twp.</b>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <b>Stanberry, Mo.</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Plainview Resthome 6 wks</b>		d. STREET ADDRESS (If outside, give location) <b>Willow St.</b>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Mrs. Nellie May</b> Middle <b>Murphy</b> Last			4. DATE OF DEATH Month <b>Nov.</b> Day <b>2</b> Year <b>1957</b>
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 7, 1877</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		9b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	9. AGE (In years last birthday) <b>80</b> IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	11. BIRTHPLACE (City and state or country) <b>Gentry Co. Mo.</b>
13a. FATHER'S NAME <b>Addison Goodwine</b>		13b. MOTHER'S MAIDEN NAME <b>Martha Myrick</b>	14. NAME OF HUSBAND OR WIFE <b>June Murphy (deceased)</b>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT <b>Orville Baker, Stanberry, Mo.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocarditis</b> DUE TO (b) <b>Senility and</b> DUE TO (c) <b>Diabetes</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>4 hours</b>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>260X</b>	
20c. TIME OF INJURY Hour <b>7:00</b> Month <b>Sept.</b> Day <b>57</b> Year <b>57</b> a.m. p.m.		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION <b>Stanberry</b> COUNTY <b>Gentry</b> STATE <b>Mo.</b>	
21. I attended the deceased from <b>16 Sept 57</b> to <b>2 Nov 57</b> and last saw her alive on <b>2 Nov 57</b> Death occurred at <b>7:00 P.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Dr. A. M. Kernell D.O.</b> (Degree or title)		22b. ADDRESS <b>Albany, Missouri</b>	
22c. DATE SIGNED <b>4 Nov 57</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>11/5/57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>High Ridge</b>	23d. LOCATION (City, town, or county) (State) <b>Stanberry, Gentry Mo.</b>
24. FUNERAL DIRECTOR <b>Skullie's Mortuary, Stanberry</b> ADDRESS		25. DATE RECD. BY LOCAL REG. <b>11-5-'57</b>	26. REGISTRAR'S SIGNATURE <b>Mrs. L. W. Bare</b>

MEDICAL CERTIFICATION

(Licensed Embalmer's Statement on Reverse Side)

420

MO.

~~D. O. S. Merrill~~

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 *Lester H. Phillips* .....  
Licensed Embalmer No. *1898* .....  
P. O. Address *Stouffville* .....

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.