

Health
& Welfare
Public
Service

.S. 300
v. 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

STANDARD CERTIFICATE OF DEATH

FILED DEC 9 - 1957

39315

STATE FILE NUMBER

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 1300

1. PLACE OF DEATH a. COUNTY Buchanan			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. Methodist Hosp.		Length of stay in 1b 50 years	d. STREET ADDRESS (If outside, give location) 2209 Duncan St.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Margaret Middle Ellen Last Murphy			4. DATE OF DEATH Month Nov. Day 19 Year 1957		
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 15, 1887	9. AGE (In years last birthday) IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) employee		10b. KIND OF BUSINESS OR INDUSTRY Furrier	11. BIRTHPLACE (City and state or country) Wilson County, Kansas		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Joseph Jefferies			14. MOTHER'S MAIDEN NAME Sarah Jane Farris		
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. 491-09-5094	17. INFORMANT Address 6017 So. Park Morton Grove, Ill. Mrs. Marguerite Kent		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebravascular accident					INTERVAL BETWEEN ONSET AND DEATH 30 hours
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) Hypertensive and arteriosclerotic cardiovascular disease		443X years	
DUE TO (c) previous cerebrovascular accident 6 years ago					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2
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.)				
20c. TIME OF INJURY Hour <input type="checkbox"/> Month, Day, Year a. m. <input type="checkbox"/> p. m. <input type="checkbox"/>					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION St. Joseph, Missouri		STATE
21. I attended the deceased from 11-18-57 to 11-19-57 and last saw her ^{him} alive on 11-19-57 Death occurred at 11:00 A. m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE Ronald J. Lillard, M.D. (Degree or title)			22b. ADDRESS 902 Edmond St. St. Joseph, Mo.		22c. DATE SIGNED 11/20/57
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 11/21/57	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery		23d. LOCATION (City, town, or county) (State) St. Joseph, Missouri	
24. FUNERAL DIRECTOR Heaton-Bowman		ADDRESS St. Joseph, Missouri	25. DATE RECD. BY LOCAL REG. Nov. 26, 1957	26. REGISTRAR'S SIGNATURE Mrs. Robert Fulton	

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 Eugene Wood

Licensed Embalmer No. 3804

P. O. Address 314 So 10th St, Hk

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.