

Health,  
& Welfare  
Public  
Service

FILED DEC 9 - 1957

STANDARD CERTIFICATE OF DEATH

43100

STATE FILE NUMBER

Registration District No. 333 Primary Registration District No. 3074 Registrar's No. 200

S. 300  
v. 1-56

1. PLACE OF DEATH a. COUNTY <u>Scott</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>New Madrid</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Sikeston</u>		c. CITY OR TOWN <u>Matthews</u> <u>0720</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Mo. Delta Comm. Hosp.</u>		d. STREET ADDRESS (If outside, give location) <u>Route # 2</u>	
Length of stay in 1b <u>37 Hrs.</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>May</u> Middle <u>Lilly</u> Last <u>Murphy</u>	4. DATE OF DEATH Month <u>11</u> Day <u>21</u> Year <u>57</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-3-1929</u>	9. AGE (In years last birthday) <u>28</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>	11. BIRTHPLACE (City and state or country) <u>Morroe Co., Mississippi</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13. FATHER'S NAME <u>William Dodd</u>	14. MOTHER'S MAIDEN NAME <u>Isabell Copeland</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknowns) (If yes, give war or dates of service) <u>  </u>	16. SOCIAL SECURITY NO. <u>  </u>	17. INFORMANT <u>Isabell Dodd</u> Address <u>Matthews, Missouri</u>
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, Bronchio</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>  </u> DUE TO (c) <u>  </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>  </u>		

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.) <u>  </u>
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20c. TIME OF INJURY. Hour . Month, Day, Year a. m. <u>  </u> p. m. <u>  </u>	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.) <u>  </u>	20f. CITY, TOWN, OR LOCATION <u>  </u>	COUNTY <u>  </u>	STATE <u>  </u>
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21. I attended the deceased from <u>11-18-57</u> to <u>11-21-57</u> and last saw her/him alive on <u>11-21-57</u> Death occurred at <u>9:00 A.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <u>AS Walters MD</u>	22b. ADDRESS <u>Matthews Mo</u>	22c. DATE SIGNED <u>11-23-57</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11-23-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Matthews Cem</u>	23d. LOCATION (City, town, or county) (State) <u>Matthews Mo.</u>
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24. FUNERAL DIRECTOR <u>Abraham Funeral Home</u> <u>Sikeston, Mo</u> (Licensed Embalmer's Statement on Reverse Side)	25. DATE RECD. BY LOCAL REG. <u>11-28-57</u>	26. REGISTRAR'S SIGNATURE <u>Wm. C. Hunter</u>
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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. Coroner cannot certify to a death due to natural causes. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE.

DATE RECEIVED DEC 8 1957

SCOTT CO. HEALTH DEPT.

CO. FILE No. 1257-246

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 J. Smith  
Licensed Embalmer No. 267

P. O. Address Cran, 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.