

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-001453

STATE FILE NUMBER

FILED JAN 21 1959

Registration District No. 149 Primary Registration District No. 1002

Registrar's No. 96

300
-57

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| 1. PLACE OF DEATH a. COUNTY Jackson | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson | | | | | | | | | | | | | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) Kansas City | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | c. CITY OR TOWN Kansas City | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | | | | | | | | | | | | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Neurological Hosp. | | | Length of stay in lb 68 yrs | | d. STREET ADDRESS (If outside, give location) 3136 Grand Ave. | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First JOHN Middle MURPHY Last MURPHY | | | | 4. DATE OF DEATH Month Jan Day 4 Year 1959 | | | | | | | | | | | | | | | | |
| 5. SEX Male | | 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 May 30, 1890 | | 9. AGE (In years last birthday) 68 | | 10. FUNDER 1 YEAR Months 11 Days 14 Hours 15 Min. | | 11. IF UNDER 24 HRS. | | | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dep. Sheriff | | | | 10b. KIND OF BUSINESS OR INDUSTRY Law Enforcement | | 11. BIRTHPLACE (City and state or country) Kansas City, Mo. | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | | | | | | | | | | |
| 13a. FATHER'S NAME Con Murphy, Sr. | | | | 13b. MOTHER'S MAIDEN NAME Mary A. Sheibley | | | | 14. NAME OF HUSBAND OR WIFE Lita Murphy | | | | | | | | | | | | |
| 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. 496-01-4966 | | 17. INFORMANT Address Con Murphy, 408 W. 68th Terrace | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Tuberc Pneumonia | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | |
| 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 _____ a.m. _____ p.m. | | | 20d. INJURY OCCURRED WHILE AT <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 Kansas City | | COUNTY Mo. | | STATE | |
| 21. I attended the deceased from _____, to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | | | | | | | | | | | | | | | | |
| 22a. SIGNATURE Nepton Owens Owens (Degree or title) ³ | | | | | | 22b. ADDRESS 1034 Rialto Bldg | | | | 22c. DATE SIGNED 1-7-59 | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE Jan 7, 1959 | | 23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery | | | 23d. LOCATION (City, town, or county) (State) Kansas City, Mo. | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR Mellody-McGilley-Eylar Funeral Home Woodland-Linwood | | | | | | 25. DATE RECD. BY LOCAL REG. 1-7-59 | | 26. REGISTRAR'S SIGNATURE Irene Marshall | | | | | | | | | | | | |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

Hugh H. OWBENS

5736 Arch. 6/1/19

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 *J. B. Ryan*

Licensed Embalmer No. ⁷⁹⁹⁹

P. O. Address *EC*

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.