

FRI. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 25 1959

59-028403

Registration District No. 53 Primary Registration District No. 3010 Registrar's No. 294 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Cape Girardeau</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>Union</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Cape Girardeau</u>		c. CITY OR TOWN <u>Anna</u>	
Length of stay in 1b <u>2 Days</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Osteopathic Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>310 Sycamore Street</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Minnie</u> Middle <u>Susan</u> Last <u>Murphy</u>			4. DATE OF DEATH Month <u>August</u> Day <u>14</u> Year <u>1959</u>			
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9-9-1888</u>	9. AGE (last birthday) <u>76</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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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>Own Home</u>	11. BIRTHPLACE (City and state or country) <u>Union County, Illinois</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>James Moake</u>	13b. MOTHER'S MAIDEN NAME <u>Paulina Knight</u>	14. NAME OF HUSBAND OR WIFE <u>S. S. (Pat) (Deceased)</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, <u>No</u> or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Mrs. M. West Elgin, Illinois</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>BRONCHIAL PNEUMONIA</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>3. Myocardiosis, 4. Senility</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
<u>1. Nephritis, 2. Arteriosclerosis with hypertension</u>		

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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____ Month, Day, Year _____	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 COUNTY _____ STATE _____
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21. I attended the deceased from <u>Aug 12, 1959</u> to <u>Aug 14, 1959</u> and last saw <sup>her</sup> alive on <u>Aug 13, 1959</u> Death occurred at <u>12:20 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <u>R. M. Stevenson</u> (Degree or title)	22b. ADDRESS <u>Hirsch Building D. O. Cape Girardeau, Mo</u>	22c. DATE SIGNED <u>8/18/59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Aug. 16, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Casper</u>	23d. LOCATION (City, town, or county) <u>Union County, Illinois</u>
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24. FUNERAL DIRECTOR <u>Hal R. McCarty</u> ADDRESS <u>Anna, Illinois</u>	25. DATE RECD. BY LOCAL REG. <u>8-21-1959</u>	26. REGISTRAR'S SIGNATURE <u>Irene Kasten</u>
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DOCUMENT MEDICAL CERTIFICATION BY AFFIDAVIT OF

AUG 27 1959

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*Hal R. McCarty*

Licensed Embalmer No. Ill. 8292

P. O. Address Anna, Illinois

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.