

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-032984

FILED VS OCT 5 1959

Registration District No. 84 Primary Registration District No. 3038 Registrar's No. 102

STATE FILE NUMBER

DEED

1. PLACE OF DEATH a. COUNTY Linn				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Chariton						
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Brookfield		Length of stay in 1b 10 days		c. CITY OR TOWN Summer		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION McLarney Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) ABBIE ELLA MURPHY				4. DATE OF DEATH Month Sept. Day 27 Year 1959						
5. SEX F	6. COLOR OR RACE W	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 7-14-1872	9. AGE (last birthday) 87	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (City and state or country) Lee County, Iowa		12. CITIZEN OF WHAT COUNTRY US			
13a. FATHER'S NAME Samuel Pore			13b. MOTHER'S MAIDEN NAME Sible - -			14. NAME OF HUSBAND OR WIFE Edward E. 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. None		17. INFORMANT Address Mrs. Alice Lomax, Chillicothe, Mo.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.) DUE TO (b) Generalized arteriosclerosis DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH 1 wk. 5 year.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Senility.						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				
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 - s.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 -	
21. I attended the deceased from Sept. 10, 1959 , to Sept. 27, 1959 and last saw her/him alive on Sept. 27, 1959 . Death occurred at Sept. 27, 1959 9:30 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.										
22a. SIGNATURE H.W. Dehman Sr.				(Degree or title)		22b. ADDRESS 3147. main Bradford Mo.		22c. DATE SIGNED 9/28/59		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Sept. 29, 1959	23c. NAME OF CEMETERY OR CREMATORY Lakeside Cemetery			23d. LOCATION (City, town, or county) Summer, Mo.				
24. FUNERAL DIRECTOR Wright Funeral Home, Brookfield, Mo.				ADDRESS		25. DATE RECD. BY LOCAL REG. 10-1-59		26. REGISTRAR'S SIGNATURE Katharine Johnson Dep.		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

JAN 12 1960

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 _____

Harold B. Wright

Licensed Embalmer No. 3718

P. O. Address Brookfield, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.