

# URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

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STATE FILE NUMBER

Registration District No. 242 Primary Registration District No. 5830 Registrar's No. 17

INDEXED

1. PLACE OF DEATH a. COUNTY <u>New Madrid</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>Near Matthews, Mo.</u>		c. CITY OR TOWN <u>Near Matthews, Mo.</u>	
Length of stay in lb <u>30 yrs</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Home</u>		d. STREET ADDRESS (If outside, give location) <u>4 Miles S. W. of Matthews, Missouri</u>	
Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Coy</u> Middle <u>An</u> Last <u>Myrick</u>			4. DATE OF DEATH Month <u>Dec.</u> Day <u>21</u> Year <u>1959</u>		
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>5/10/1876</u>	9. AGE (last birthday) <u>83</u>	IF UNDER 1 YEAR Months <u>    </u> Days <u>    </u>	IF UNDER 24 HR 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>Farmer, Ret.</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	11. BIRTHPLACE (City and state or country) <u>Cassville, Ky</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>Thomas J. Murphy</u>	13b. MOTHER'S MAIDEN NAME <u>Lettie Sullivan</u>	14. NAME OF HUSBAND OR WIFE <u>Nancy Johnson</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>    </u>	17. INFORMANT Address <u>Mr. Raymond Myrick Matthews, Mo</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>Cerebral Hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</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>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>    </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
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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.) <u>    </u>
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20c. TIME OF INJURY Hour <u>    </u> Month, Day, Year <u>    </u> 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 COUNTY STATE <u>    </u>
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21. I attended the deceased from <u>1-1-58</u> to <u>12-21-59</u> and last saw <u>her</u> alive on <u>12-21-59</u> Death occurred at <u>4:15 A.M. Dec 21, 1959</u> on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <u>A. S. Sarno, M.D.</u> (Degree or title)	22b. ADDRESS <u>Shelbourn Mo.</u>	22c. DATE SIGNED <u>12-24-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Dec 23, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove</u>	23d. LOCATION (City, town, or county) (State) <u>Karmak, Illinois</u>
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24. FUNERAL DIRECTOR <u>Mc Mickle East Prairie, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>12-24-59</u>	26. REGISTRAR'S SIGNATURE <u>Mathyn L. Mc Bain</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 *Edwin McTigue*

Licensed Embalmer No. 4695

P. O. Address East Prairie

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.