

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-038489

EILED VS OCT 27 1960 149

Registration District No. \_\_\_\_\_ Primary Registration District No. 1002 Registrar's No. 5095 STATE FILE NUMBER

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <b>Jackson</b>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		a. STATE <b>Mo.</b>		b. COUNTY <b>Jackson</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>235 Ward Parkway</b>		Length of stay in 1b <b>Life</b>		c. CITY OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. STREET ADDRESS <b>235 Ward Parkway</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>235 Ward Parkway</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First <b>Lee</b>		Middle <b>Murphy</b>		Month <b>Oct.</b>		Day <b>8,</b>	
Year <b>1960</b>							
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>5-22-1883</b>	9. AGE (last birthday) <b>77</b>	IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Kansas City, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S.</b>	
13a. FATHER'S NAME <b>Dr. Hugh Charles Murphy</b>			13b. MOTHER'S MAIDEN NAME <b>Martha Cook</b>		14. NAME OF HUSBAND OR WIFE <b>Esther Murphy</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>495-03-9325</b>		17. INFORMANT <b>Esther Murphy</b> Address <b>235 Ward Parkway</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b>						<b>3 Hours</b>	
DUE TO (b) <b>Arteriosclerotic Coronary thrombosis "</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) <b>1) Recent Gastric Ulcer &amp; Hemorrhage.</b> <b>2) Diabetes Mellitus.</b>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N. <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 _____ 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
21. I attended the deceased from <b>1957</b> to <b>8 Oct. 1960</b> and last saw <sup>him</sup> live on <b>7 Oct. 1960</b>				Death occurred at <b>8:20</b> <b>A.</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Philip G. Kaul M.D.</b>			22b. ADDRESS <b>411 Nichols Road</b>		22c. DATE SIGNED <b>8 Oct. 1960</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10/11/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt Washington</b>		23d. LOCATION (City, town, or county) (State) <b>Kansas City Mo.</b>		
24. FUNERAL DIRECTOR ADDRESS <b>Stine &amp; McClure</b>			25. DATE RECD. BY LOCAL REG. <b>10-10-60</b>		26. REGISTRAR'S SIGNATURE <b>H. L. Dwyer</b>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Philip G. Kaul

**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 J. J. Swalter

Licensed Embalmer No. 2744

P. O. Address H. C. M.

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.

02-07-01