

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-041314

STATE FILE NUMBER

FD VS NOV 20 1960

Registration No. 57 Primary Registration District No. 5202 Registrar's No. 11

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Carroll</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Eugene Twp.</b>		Length of stay in lb <b>Life</b>		c. CITY OR TOWN <b>Eugene Twp.</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>2 Mi.N.E.of Wakenda</b>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>2 Mi.N.E.of Wakenda</b>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED - (Type or print) First <b>LILBERT</b> Middle <b>LESTER</b> Last <b>MURPHY</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>14</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>12/17/1879</b>	9. AGE (last birthday) <b>80</b>	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) <b>Farming</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (City and state or country) <b>Carroll County, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13a. FATHER'S NAME <b>Jess Murphy</b>			13b. MOTHER'S MAIDEN NAME <b>Elizabeth Adams</b>		14. NAME OF HUSBAND OR WIFE <b>May Thomas 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.		17. INFORMANT Address <b>Mrs.Lilbert Murphy, Wakenda, Mo.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial insufficiency</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2 hr.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Infirmities of old age.</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)					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		
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>Nov. 14, 1960</b> to <b>Nov. 14/60</b> and last saw him alive on <b>Nov. 14, 1960</b>				Death occurred at <b>5:30 P.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
21a. SIGNATURE <b>R. Hamilton Staton, M.D.</b>				22b. ADDRESS <b>Carrollton, Mo</b>		22c. DATE SIGNED <b>Nov. 15/60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>11/17/1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>		23d. LOCATION (City, town, or county) <b>Carrollton Mo.</b>		(State) <b>0</b>	
24. FUNERAL DIRECTOR <b>Gibson Funeral Home, Carrollton, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>Nov. 20 - 1960</b>		26. REGISTRAR'S SIGNATURE <b>Pearl Koch</b>	

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 \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_, working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Ben W. Gibson

Licensed Embalmer No. 2961

P. O. Address Carroll

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