

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-004878
STATE FILE NUMBER

Registration District No. 75 Primary Registration District No. 3015 Registrar's No. 20

AMENDED

FILED VS MAR 8 1961

1. PLACE OF DEATH a. COUNTY Clinton		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Clinton	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Cameron		c. CITY OR TOWN Cameron	
Length of stay in 1b 4 days		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Cameron Community Hospt		d. STREET ADDRESS (If outside, give location) West Third St	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First Kathleen Middle Murphy Last Murphy			4. DATE OF DEATH Month 2 Day 28 Year 1961		
--	--	--	---	--	--

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 2-19-1886	9. AGE (last birthday) 75	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) House keeper	10b. KIND OF BUSINESS OR INDUSTRY Catholic Priest	11. BIRTHPLACE (City and state or country) Richmond Mo.	12. CITIZEN OF WHAT COUNTRY U/S/A
--	---	---	---

13a. FATHER'S NAME Martain Murphy	13b. MOTHER'S MAIDEN NAME Mary Moran	14. NAME OF HUSBAND OR WIFE Deceased
---	--	--

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 Mrs. Margart Shinn Lexington Mo.	Address
---	--	--	---------

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) Lobar pneumonia		4 days
DUE TO (b) Rt middle lobe -		
DUE TO (c) arterio sclerotic heart disease		
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 checked="" 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 **Feb 25 1961** to **Feb 28 1961** and last saw her alive on **Feb 28 1961**
Death occurred at **6:30 p.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>[Signature]</i>	(Degree or title)	22b. ADDRESS Mrs M P Cameron, Mrs	22c. DATE SIGNED 3-3-61
--------------------------------------	-------------------	---	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 3-3-1961	23c. NAME OF CEMETERY OR CREMATORY Valvary Cemetery	23d. LOCATION (City, town, or county) (State) Lexington Mo
--	------------------------------	---	--

24. FUNERAL DIRECTOR Poland Funeral Home Cameron Mo.	ADDRESS	25. DATE RECD. BY LOCAL REG. Mar 3 1961	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>
--	---------	---	---

DATE AMENDED
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

MAR 8 1961

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 Robert F Polow

Licensed Embalmer No. 4777
922 West
P. O. Address Camden

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.