

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-037107

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4897

STATE FILE NUMBER

AMENDED

FILED OCT 19 1961

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>JACKSON</u>	b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u>	a. STATE <u>MISSOURI</u>	b. COUNTY <u>JACKSON</u>
Length of stay in lb <u>11 Yrs</u>		c. CITY OR TOWN <u>KANSAS CITY</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>5609 E 24 ST</u>		d. STREET ADDRESS (If outside, give location) <u>5609 E 24 ST</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)	4. DATE OF DEATH
<u>THOMAS PATRICK MURPHY</u>	<u>OCTOBER 2 1961</u>

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9-1-1897</u>	9. AGE (last birthday) <u>64</u>	IF UNDER 1 YEAR	IF UNDER 24 HR
				Months	Days	Hours

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Truck Driver</u>	11. BIRTHPLACE (City and state or country) <u>IDA GROVE IOWA</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
--	---	--	---

13a. FATHER'S NAME <u>William Murphy</u>	13b. MOTHER'S MAIDEN NAME <u>Jennie Rose</u>	14. NAME OF HUSBAND OR WIFE <u>Mabel Murphy</u>
--	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>	16. SOCIAL SECURITY NO. <u>WWT</u>	17. INFORMANT Address <u>MRS Mabel Murphy 5609 E 24 ST</u>
--	------------------------------------	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:	
IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	
DUE TO (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 checked="" 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.)
--	---	--

20c. TIME OF INJURY	Hour	Month, Day, Year
	a.m. p.m.	

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 _____ to _____ and last saw her/him alive on _____.

Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Hugh A Owens Coroner</u>	22b. ADDRESS <u>152 Union Station</u>	22c. DATE SIGNED <u>10-3-61</u>
--	---------------------------------------	---------------------------------

23a. BURIAL, CREMATION, OR DISPOSAL (Specify) <u>BURIAL</u>	23b. DATE <u>10-4-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt Washington</u>	23d. LOCATION (City, town, or county) (State) <u>Independence MO</u>
---	----------------------------	---	--

24. FUNERAL DIRECTOR ADDRESS <u>Sheil Funeral Home K.C. Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>10-3-61</u>	26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>
---	---	--

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF H. OWENS

ITEM NO. SHOULD READ

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 James A. Reed

Licensed Embalmer No. 4954

P. O. Address K.P. Mo

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.