WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

# MISSOURI STATE BOARD OF HEALTH
## BUREAU OF VITAL STATISTICS
### CERTIFICATE OF DEATH

37307

1 PLACE OF DEATH

County .....

Township ..... Registration District No. 791 File No. .....

or

Village ..... Primary Registration District No. 1003 Registered No. 10653

or

City St. Louis (NO. 4123 Warne av St.; N Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Mollie E. Murphy

**PERSONAL AND STATISTICAL PARTICULARS**

3 SEX Female

4 COLOR OR RACE White

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Married

6 DATE OF BIRTH Jan (Month) 31 (Day), 1857 (Year)

7 AGE 61 yrs. 9 mos. ..... ds.

If LESS than 1 day, ..... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work at Home
(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE (City or town, State or foreign country) Louisville Ky

PARENTS

10 NAME OF FATHER George W. Ford

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Kentucky

12 MAIDEN NAME OF MOTHER Rebecca Jones 8

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ohio

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frank Murphy

(Address) 4123 Warne

15 Filed NOV - 1 1918, 19 Max C. Starkloff Registrar

**MEDICAL CERTIFICATE OF DEATH**

16 DATE OF DEATH Oct. (Month) 31 (Day), 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from September 26 1918, to death, 10-31, 1918, that I last saw her alive on October 28, 1918, and that death occurred, on the date stated above, at 8 40 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

46B 40

(Duration) — yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Edwin Sauter M. D.

Oct. 31, 1918 (Address) 1331 N. 7th St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL Bellefontaine Cemetery

DATE OF BURIAL Nov. 2, 1918

20 UNDERTAKER Cullinane Bros

ADDRESS 1710 N. Grand Av.

# MISSOURI STATE BOARD OF HEALTH
## BUREAU OF VITAL STATISTICS
### CERTIFICATE OF DEATH

**1 PLACE OF DEATH**

County .....

Township..... Registration District No..... File No. .....
*or*
Village ..... Primary Registration District No. ..... Registered No. .....
*or*
City..... (NO....., .....St.;.....Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

**2 FULL NAME**.....

**WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD**

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word) |
|---|---|---|
| | | |

6 DATE OF BIRTH

.....191.....
(Month) (Day) (Year)

7 AGE

.....yrs.....mos.....ds.

If LESS than 1 day,.....hrs. or.....min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work.....

(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE
(City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER
(City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address).....

15

Filed....., 191....., .....
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

....., 191.....
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from

....., 191....., to....., 191.....

that I last saw h.....alive on....., 191.....,

and that death occurred, on the date stated above, at.....m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed).....M. D.

....., 191..... (Address).....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL .....191.....

20 UNDERTAKER | ADDRESS