

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

1. PLACE OF DEATH

County..... Registration District No. **701**
 Township..... Primary Registration District No. **10005**
 City **St. Louis** (No. **4852**, **St. Louis**) St. **15415** Ward

2. FULL NAME

(a) Residence, No. **4852** St. **St. Louis** Ward **26**
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female**
 4. COLOR OR RACE **White**
 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **married**
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF **Peter Murphy**
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) **May 26th 1869**
 7. AGE YEARS MONTHS Days If LESS than 1 day, hrs. or min.
49 10 12
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work **at Home**
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) **Ireland**

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

14.

INFORMANT **Peter Murphy**
 (Address) **4852 St. Louis av**

15.

FILED **May 6 1919** **Man & Starck off**
 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **4/8 1919**
 17. I HEREBY CERTIFY, That I attended deceased from **April 8**, 1919, to **April 8**, 1919, that I last saw him alive on **April 8**, 1919, and that death occurred, on the date stated above, at **6:30 P.M.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Apoplexy but

CONTRIBUTORY **Chronic Interstitial Nephritis**
 (SECONDARY) (duration) X yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH:.....

DID AN OPERATION PRECEDE DEATH? **No** DATE OF.....

WAS THERE AN AUTOPSY? **No**

WHAT TEST CONFIRMED DIAGNOSIS? **None**

(Signed) **Dwight Simpson**, M. D.

419, 1919 (Address) **7018th St**

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

St. Albans **4-11 1919**

20. UNDERTAKER

ADDRESS

Arthur J. Donnelly **2039 Wash**

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

K. E.—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.

