

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

Do not use this space.

16973

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1003**
 City **St. Louis Mo** (No. **3218 N 11th St**)..... St. Ward)

File No.....
 Registered No. **4936**

2. FULL NAME

Mathilda Murphy
 (a) Residence, No. **3218 N. 11th St**, St. **26** Ward.
 (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. 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 OF (OR) WIFE OF **Theodore Murphy**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **April 19-1883**

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
44 1 5

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **Housewife**
 (b) General nature of industry, business, or establishment in which employed (or employer).....
 (c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN) **Ills.**
 (STATE OR COUNTRY)

PARENTS
 10. NAME OF FATHER **J. Lutz**
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) **Germany**
 (STATE OR COUNTRY)
 12. MAIDEN NAME OF MOTHER **Don't know**
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) **Germany**
 (STATE OR COUNTRY)

14. INFORMANT **Theodore Murphy**
 (Address) **3218 N. 11th St**

15. FILED **MAY 26 1927** **May C. Starceoff**
 REGISTER

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **May 24 19 27**

17. I HEREBY CERTIFY, That I attended deceased from **Apr 25**, 19**27**, to **May 24**, 19**27**, that I last saw him alive on **May 23**, 19**27**, and that death occurred, on the date stated above, at **1:20 a.m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Hemorrhage
Apoplexy
82 H
90 D (duration) yrs. mos. **90** ds.
Paralysis, Hemiplegia
 CONTRIBUTORY (SECONDARY) (duration) yrs. mos. **30** ds.

18. WHETHER DISEASE CONTRACTED IF NOT PLACE OF DEATH? **7401**

0 DID AN OPERATION PRECEDE DEATH? **no.** DATE OF..... WAS THERE AN AUTOPSY? **no.**

WHAT TEST CONFIRMED DIAGNOSIS? **Symptoms**
 (Signed) **Herman L. Wittens**, M. D.
May 24, 19 27 (Address) **2728 N. 11 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **Red. Bud. Ills.** DATE OF BURIAL **May 27 19 27**

20. UNDERTAKER **By Leidner Ind Co. N. Market St** ADDRESS **14 17**

WRITE CLEARLY, 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.

