

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

Do not use this space.

1. PLACE OF DEATH

County.....
Township.....
City.....

Registration District No. **701**
Primary Registration District No. **1003**

File No. **22148**
Registered No. **6323**
Sl. (Ward)

2. FULL NAME

James John Murphy
(a) Residence. No. **2528 1/2 St. Louis ave**, **20** Ward.
(Usual place of abode)

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 **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Single**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **July 18, 1864**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
63 10 25

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) **St. Louis**
(STATE OR COUNTRY) **Mo**

PARENTS
10. NAME OF FATHER **John Murphy**
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) **Ireland**
12. MAIDEN NAME OF MOTHER **Mary Quinn**
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) **Ireland**

14. INFORMANT **Mrs Catherine Scates**
(Address) **2528 1/2 St. Louis ave**

15. FILED **14 1928** **May C. Stanley** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **June 13 1928**

17. I HEREBY CERTIFY, That I attended deceased from **April 1928** to **June 13 1928**, that I last saw him alive on **June 4, 1928**, and that death occurred, on the date stated above, at **5 a.m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Interstitial Nephritis
129 A
(duration) **1** yrs. **6** mos. **ds.**
CONTRIBUTORY (SECONDARY) **Chronic Nephritis**
(duration) **1** yrs. **6** 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? **Clinical**
(Signed) **R. H. Sewer**, M. D.
4/13, 1928 (Address) **7342 St. Louis**

*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 **Calvary Cemetery** DATE OF BURIAL **June 15 1928**

20. UNDERTAKER **Goodhart + Goodhart Und Co** ADDRESS **2228 St. Louis ave**

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.

