

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

Do not use this space.

7633

1. PLACE OF DEATH

County..... Registration District No. 797
 Township..... Primary Registration District No. 1002
 City St. Louis Mo. (No.) Sanitarium St. Ward)

File No.
 Registered No. 1993

2. FULL NAME

James Murphy
 (a) Residence. No. 3857 Russel Bl. 13 Ward.
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred 37 yrs. 2 mos. 27 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Nov. 12, 1893</u>		
7. AGE	YEARS <u>37</u>	MONTHS <u>2</u>
	DAY <u>26</u>	IF LESS than-1 day, hrs. or min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Sanitarium</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>Unknown</u> (c) Name of employer		

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-8 1931
 17. I HEREBY CERTIFY, That I attended deceased from 1-26 1931 to 2-8 1931 that I last saw him alive on 2-8 1931 and that death occurred, on the date stated above, at 8:45 p. m.
 THE CAUSE OF DEATH* WAS AS FOLLOWS:

Ruptured aneurysm (Aorta)
 (duration) yrs. mos. 14 da.
 CONTRIBUTORY (SECONDARY) (Parent) General Paralytic of Insane (Syphilitic)
 (duration) yrs. mos. 16 da.

PARENTS

9. BIRTHPLACE (CITY OR TOWN)..... St. Louis Missouri
 (STATE OR COUNTRY)
 10. NAME OF FATHER Unknown
 11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
 (STATE OR COUNTRY)
 12. MAIDEN NAME OF MOTHER

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH.....
 DID AN OPERATION PRECEDE DEATH? no DATE OF 1
 WAS THERE AN AUTOPSY? yes
 WHAT TEST CONFIRMED DIAGNOSIS Autopsy X-Ray Wasserman of clinical
 (Signed) Dr. Mullman M.D.
2-9, 1931 (Address) 5300 Arsenal

14. INFORMANT Dr. Mullman M.D.
 (Address) 5300 Arsenal

*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.

15. FILED 14 1931 Max E. Harker
 REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL St. Matthews Cemetery DATE OF BURIAL Feb 16 1931
 20. UNDERTAKER Julius W. Schmitz ADDRESS 3934 Russel Blvd

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.

WHITE PRINTED WITH NONFADING INK—THIS IS A PERMANENT RECORD

