

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

Do not use this space.

7692

File No. _____
Registered No. 2054
St. _____ Ward _____

1. PLACE OF DEATH

County _____ Registration District No. 791
Township _____ Primary Registration District No. 1003
City St. Louis mo (No. Christian Hospital)

2. FULL NAME

Cecelia Agnes Murphy
(a) Residence. No. 4324 Oakwood ave St. 9 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. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</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>Dec 22-1902</u>				
7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
	<u>28</u>	<u>1</u>	<u>23</u>	
8. OCCUPATION OF DECEASED <u>Ant Foready Candy Dept 37</u>				
(a) Trade, profession, or particular kind of work _____				
(b) General nature of industry, business, or establishment in which employed (or employer) _____				
(c) Name of employer <u>Wright Packing Co</u>				

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

10. NAME OF FATHER James Murphy

11. BIRTHPLACE OF FATHER (CITY OR TOWN) St. Louis
(STATE OR COUNTRY) mo

12. MAIDEN NAME OF MOTHER Frances Brown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
(STATE OR COUNTRY) mo

14. INFORMANT Frances Murphy
(Address) 4324 Oakwood ave

15. FILED FEB 16 1931 19. _____
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 14 1931

17. I HEREBY CERTIFY, That I attended deceased from Feb 8, 1931, to Feb 14, 1931, that I last saw h. or alive on Feb 14, 1931, and that death occurred, on the date stated above, at 6:35 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Meningitis Pneumococic
7911 (duration) _____ yrs. _____ mos. 9 ds.

CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTACTED _____
IF NOT AT PLACE OF DEATH: _____
DID AN OPERATION PRECEDE DEATH? yes DATE OF 2-11-31
WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS _____
(Signed) D. C. Bouserman, M. D.
2-16-1931 (Address) 6123 Sacton ave

*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 Feb 17 1931

20. UNDERTAKER Frank Carroll ADDRESS 4600 Mill Bridge

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.

