

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

Do not use this space.

JAN 23 1936

42032

1. PLACE OF DEATH  
County St. Louis Registration District No. Missouri 11.23 File No. ....  
Township ..... Primary Registration District No. 6.248.B Registered No. 410  
City Jefferson Barracks (No. Veterans Administration Facility) St. .... Ward)

2. FULL NAME MURPHY, Michael P.  
(a) Residence, No. Box 252 Cuba, Missouri St. .... Ward. ....  
(Usual place of abode) (If nonresident, give city or town and State)  
Length of residence in city or town where death occurred Un yrs. kn mos. wn 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) Married  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) February 27, 1875  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
60 9 8

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Minister  
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Methodist Church  
10. Date deceased last worked at this occupation (month and year) May 1935 11. Total time (years) spent in this occupation Life

12. BIRTHPLACE (CITY OR TOWN) Elejoy  
(STATE OR COUNTRY) Tennessee

13. NAME Unavailable

14. BIRTHPLACE (CITY OR TOWN) Unavailable  
(STATE OR COUNTRY) Unavailable

15. MAIDEN NAME Unavailable

16. BIRTHPLACE (CITY OR TOWN) Unavailable  
(STATE OR COUNTRY) Unavailable

17. INFORMANT A. W. Schulz, M.D., Vet. Adm.  
(ADDRESS) Facility, Jeff. Brks., Missouri

18. BURIAL, CREMATION, OR REMOVAL  
PLACE Cuba, Missouri DATE December 6, 1935

19. UNDERTAKER C. Hoffmeister N. & L. Co.  
(ADDRESS) 7814 So. Broadway

20. FILED Dec 6 1935 J. Mowrey  
Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) December 5, 1935

22. I HEREBY CERTIFY, That I attended deceased from December 4, 1935, to December 5, 1935,  
I last saw him alive on December 5, 1935. Death is said to have occurred on the date stated above, at 10:37<sup>0</sup> p.m.

The principal cause of death and related causes of importance were as follows:  
Carcinomatosis with multiple metastases.

Other contributory causes of importance:  
Anemia, symptomatic, severe

Name of operation None Date of findings History physical, x-ray and lab.  
What test confirmed diagnosis? None Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? ..... Date of injury ..... 19.....  
Where did injury occur? ..... (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

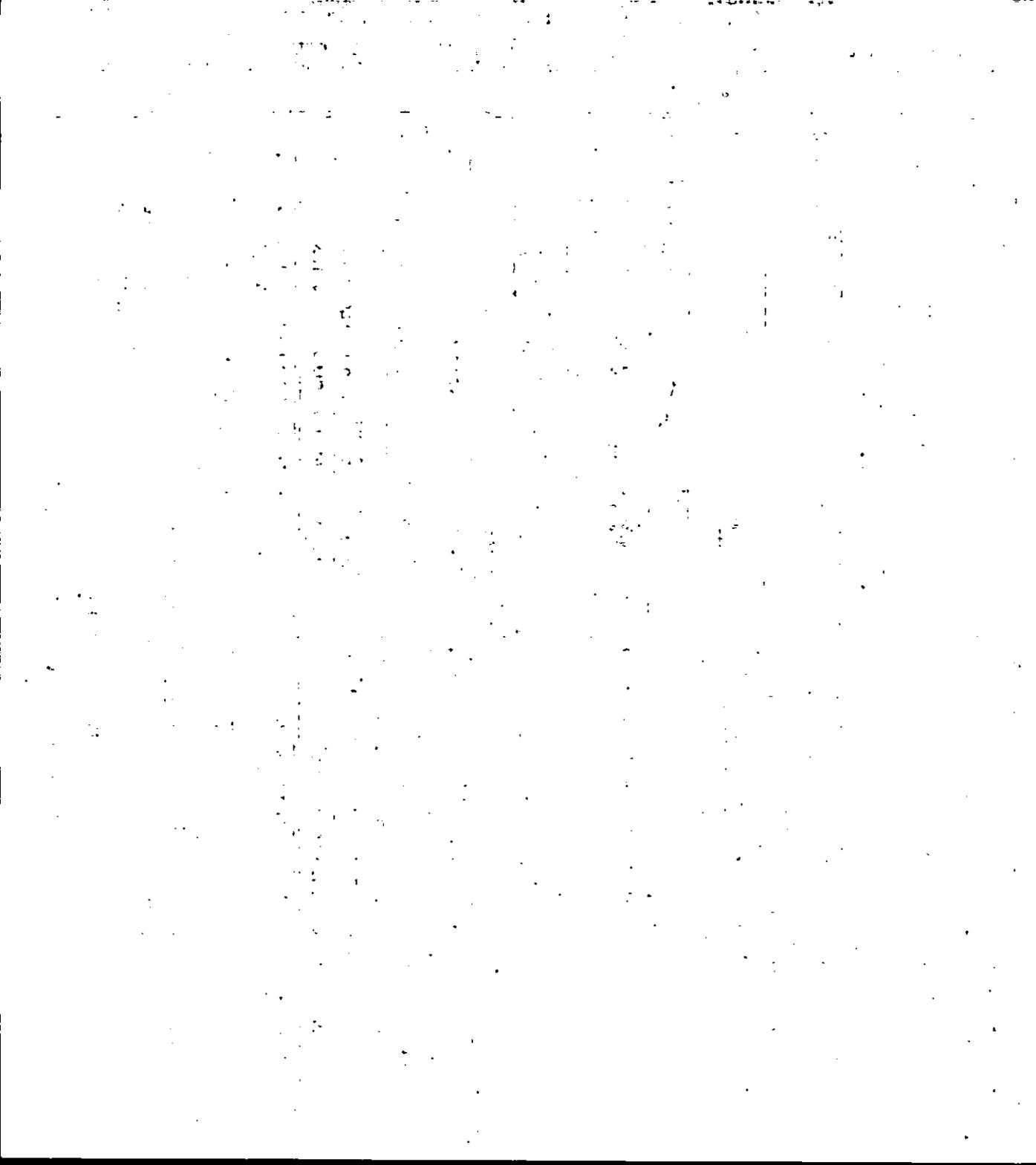
Manner of injury .....  
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....

If so, specify None  
(Signed) A. W. SCHULZ, M.D., Act., Chief, M. D.  
(Address) Medical Officer, Vet. Adm. Facility, Jeff. Brks., Mo.

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.



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BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

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**1. PLACE OF DEATH**

County St Louis

Registration District No. 1123

File No. \_\_\_\_\_

Township \_\_\_\_\_

Primary Registration District No. 6288 B

Registered No. 410

City Jefferson Barracks (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Michael P. Murphy

(a) Residence, No. \_\_\_\_\_ St., \_\_\_\_\_ 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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) M

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) \_\_\_\_\_

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
	<u>60</u>	<u>9</u>	<u>8</u>	

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. \_\_\_\_\_  
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. \_\_\_\_\_  
10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_

11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

13. NAME \_\_\_\_\_

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

15. MAIDEN NAME \_\_\_\_\_

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

17. INFORMANT (ADDRESS) \_\_\_\_\_

18. BURIAL, CREMATION, OR REMOVAL

PLACE \_\_\_\_\_ DATE \_\_\_\_\_ 19\_\_\_\_

19. UNDERTAKER (ADDRESS) \_\_\_\_\_

20. FILED 12-6 1935 G. Moury Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 5, 1935

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_

I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

The principal cause of death and related causes of importance were as follows:

Carcinomatosis, with multiple metastases Date of onset \_\_\_\_\_  
Primary seat - left breast

Other contributory causes of importance: \_\_\_\_\_

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place. \_\_\_\_\_

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

If so, specify \_\_\_\_\_

(Signed) A. W. Schulz M. D.

(Address) Jefferson Barracks

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.

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