

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.

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

Do not use this space.

JAN 20 1937

## 1. PLACE OF DEATH

County.....

Registration District No.....

## a. Township.....

Primary Registration District No.....

City St. Louis, Missouri City Hospital No. 1

B. 12438

John James Murphy

## 2. FULL NAME

(a) Residence, No.....

(Usual place of abode)

1624 South Cincinnati St.,n.r. Ward.Oklahoma City, Okla.

(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

male

## 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 OFunknown

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

June 30, 1881

## 7. AGE

YEARS

MONTHS

DAYS

If LESS than 1

day, .....hrs.

or .....min.

55

5

0

## OCCUPATION

8. Trade, profession, or particular  
kind of work done, as spinner,  
sawyer, bookkeeper, etc.....oil driller9. 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)

Tipperary Ireland

## MOTHER / FATHER

## 13. NAME

## 14. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

## 15. MAIDEN NAME

## 16. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

## 17. INFORMANT

(ADDRESS)

Hosp. Info. M.H. Kent  
City Hospital No. 1

## 18. BURIAL, CREMATION, OR REMOVAL

PLACE

Washington D.C. DATE 12-7, 1936

## 19. UNDERTAKER

(ADDRESS)

W. Richter  
3500 Budge St

## 20. FILED

DEC 30 1936J. B. Debeck  
Registrar.

## MEDICAL CERTIFICATE OF DEATH

## 21. DATE OF DEATH (MONTH, DAY, AND YEAR)

11/30/36

, 19

## 22. I HEREBY CERTIFY, That I attended deceased from

11/25/36

, 19

to 11/30/36

, 19

I last saw him alive on 11/30/36, 19..... Death is saidto have occurred on the date stated above, at 6.55 p.m.

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

Date of onset

Lobar pneumonia  
Septicemia - etiology unknown.

Other contributory causes of importance:

Name of operation.....

Date of.....

What test confirmed diagnosis?.....

Was there an autopsy? h

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) William J. Frederick, M. D.(Address) City Hospital No. 1

