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.

REC'D JAN 11 1939

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

41235
Do not use this space.

1. PLACE OF DEATH

(a) County ..... / Registration District No. 1003 (191)

(b) Township ..... / Primary Registration District No. ..... Registered No. 10927

(c) City St. Louis (d) Street No. St. Anthony's Hospital St.
(If death occurred in Hospital or Institution, write its name instead of street and number)

(e) Length of residence in city or town where death occurred 40 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME John T. Murphy,

(a) Residence, No. 4754 N. Florissant Ave. St. 7
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word): Widower

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb. 7, 1862

7. AGE: Years 76 | Months 9 | Days 11 | If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Cutter

9. Industry or business in which work was done, as saw mill, bank, etc. Monument Wks.

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) Hannibal Mo/

FATHER

13. NAME Thomas Murphy

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

MOTHER

15. MAIDEN NAME Sarah Watson

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

17. INFORMANT Mr. John T. Murphy Jr.
(ADDRESS) 5016 Nottingham Ave.

18. BURIAL, CREMATION, OR REMOVAL
PLACE Calvary Cem. DATE 12-21-38, 19

19. FUNERAL DIRECTOR (NAME) Cullinane Brothers
(ADDRESS) 1710 N. Grand Blvd.

20. FILED DEC 20 1938 J. B. Budeck Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec. 18, 1938, 19

22. I HEREBY CERTIFY, That I attended deceased from 12/17, 1938 to 12/18, 1938

I last saw him alive on 12/18, 1938. Death is said to have occurred on the date stated above, at 9 P.M.

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

	Date of onset
Agranulocytosis	?

Other contributory causes of importance:
Chr. cholecystitis
acute chole cystitis
Chole lithiasis

Name of operation 0 Date of —
What test confirmed diagnosis? autopsy Was there an autopsy? Yes

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) Phil H. Fisherer, M. D.
(Address) 3115 S. Grand Av

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, ...

....., or by .....,

Registered Apprentice No....., working under my personal supervision.

Signed Fred Frick

Licensed Embalmer No. 3186

P. O. Address St. Louis Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.