

REC'D MAR 13 1939

 MISSOURI STATE BOARD OF HEALTH  
 BUREAU OF VITAL STATISTICS  
 CERTIFICATE OF DEATH
791  
1003

4537

Do not use this space.

## 1. PLACE OF DEATH

- (a) County ..... Registration District No. ....
- (b) Township ..... Primary Registration District No. .... Registered No. **1230**
- (c) City ST. LOUIS ..... (d) Street No. 6212 Mc PHERSON AVE 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 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME MR ANSON W. MURPHY

- (a) Residence, No. 6212 Mc PHERSON AVE St. **5** ..... (If nonresident, give city or town and State)
- (Usual place of abode, if no street address, write county or city)

## 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>MARRIED</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>CATHERINE</u>				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>JAN. 24, 1866</u>				
7. AGE	YEARS <u>73</u>	MONTHS <u>0</u>	DAYS <u>13</u>	If LESS than 1 day, ..... hrs. or ..... min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>RETIRED</u>			
	9. Industry or business in which work was done, as saw mill, bank, etc. <u>INSURANCE</u>			
	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) <u>ST. LOUIS</u> <u>Mo.</u>				
FATHER	13. NAME <u>PHILIP MURPHY</u>			
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>IRELAND</u>			
MOTHER	15. MAIDEN NAME <u>ANNIE CONNERS</u>			
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>IRELAND</u>			
17. INFORMANT <u>CATHERINE MURPHY</u> (ADDRESS) <u>6212 Mc PHERSON AVE</u>				
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>CALVARY</u> DATE <u>FEB 8</u> 19 <u>39</u>				
19. FUNERAL DIRECTOR (NAME) <u>CULLEN + KELLY</u> (ADDRESS) <u>1416 N. TAYLOR</u>				
20. <u>FEB 7 1939</u> 19..... <u>J. D. Budek</u> Local Registrar.				

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb, 6 1939

22. I HEREBY CERTIFY, That I attended deceased from Nov. 1931 to February 6 1939

I last saw h. in alive on 2-5-39 19..... Death is said to have occurred on the date stated above, at 6:30 am.

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

Coronary Sclerosis  
Arteriosclerosis  
Chronic hepatitis  
Chronic myocarditis

Date of onset

Other contributory causes of importance:

Name of operation no Date of.....

What test confirmed diagnosis? Clinical 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? no  
 If so, specify.....  
 (Signed) Thomas M. Martin / M. D.  
 (Address) 607 no Grand ave.

**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, .....

*Mark Turner*

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

Registered Apprentice No. *174* ....., working under my personal supervision.

Signed.....

*Clement M. May*

Licensed Embalmer No. *3732*

P. O. Address.....

*St. Louis*

**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.**