

U. S. No. 2
4-11-10-39
rev. 5-17-39
I X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **40007**
Registrar's No. **289**

Registration District No. **875** Primary Registration District No. **6167**

1. PLACE OF DEATH:

(a) County **VERMONT**
(b) City or town **NEVADA MISSOURI**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
STATE HOSPITAL No 3
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **29 DAYS** (Specify whether years, months or days) **3**

8. (a) PRINT FULL NAME **JANIE MURPHY**

3. (b) If veteran, name, war **MO** 3. (c) Social Security No. **NONE**

4. Sex **FEMALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **SINGLE**

6. (b) Name of husband or wife **NONE** 6. (c) Age of husband or wife if alive **NONE** years

7. Birth date of deceased **FEB 5 1855**
(Month) (Day) (Year)

8. AGE: Years **85** Months **8** Days **23** If less than one day **-** hr. **-** min.

9. Birthplace **UNKNOWN INDIANA**
(City, town, or county) (State or foreign country)

10. Usual occupation **NONE**

11. Industry or business **NONE**

12. Name **PATRICK MURPHY**

13. Birthplace **UNKNOWN IRELAND**
(City, town, or county) (State or foreign country)

14. Maiden name **UNKNOWN**

15. Birthplace **UNKNOWN UNKNOWN**
(City, town, or county) (State or foreign country)

16. (a) Informant **RECORDS STATE HOSP NO 3**

(b) Address **NEVADA MISSOURI**

17. (a) **Burial** (Burial, cremation, or removal) Date thereof **11/30/40**
(Month) (Day) (Year)

(c) Place: burial or cremation **Temp. Cem.**

18. (a) Signature of funeral director **Mark Eichinger**

(b) Address **Nebraska MO**

19. (a) **11-25-40** (Date received local registrar) (b) **Allen V. Kafa** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **ST. LOUIS**
(c) City or town **ST. LOUIS**
(If outside city or town limits, write "RURAL")
(d) ~~Street~~ No. **LITTLE SISTERS OF THE POOR** (If rural, give location)
(e) If foreign born, how long in U. S. A. **USA** years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **NOV** day **27**
year **1940** hour **5** - minute **A M.**

21. I hereby certify that I attended the deceased from **OCT 29** 1940, to **NOV 27** 1940
that I last saw **HER** alive on **NOV 27** 1940
and that death occurred on the date and hour stated above.

Immediate cause of death: **CHRONIC DEGENERATIVE MYOCARDIIS**
Due to **-**
Due to **-**

Other conditions **ARTERIOSCLEROSIS - HYPERTENSION - VARICOSE ULCERS**
(Include pregnancy within 3 months of death)
Major findings: **NONE** **SENILE DEMENTIA**
Of operations **NONE**

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: **No**

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury

23. Signature **Paul L. Barone** (M. D. or other) **MD**

Address **STATE HOSP No 3** Date signed **NOV 27**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

08

FILED DEC 11 1940

RECEIVED
District Health Officer No. 7,
District File Number 12-40-1697
Date Filed 12-4-40

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 Marsh Eichinger
Licensed Embalmer No. 2656
P. O. Address Peoria, 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.