

FILED SEP 17 1941

Primary Registration District No. 1003

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17  
9  
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County St. Louis, Mo.

(b) City or town St. Louis, Mo.  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: In my infirmary  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 days  
(Specify whether)

In this community 72 yrs.  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis

(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")

(d) Street No. 2419 Lawton  
(If rural, give location)

(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Emily Murphy

3. (b) If veteran, name war no

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 29  
year 1941 hour 12 minute 30 P. M.

4. Sex Female 5. Color or race C

6. (a) Widowed, married, divorced, widowed

6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
20 (Month) 1869 (Day) (Year)

7. Birth date of deceased \_\_\_\_\_

21. I hereby certify that I attended the deceased from July 24 1941 to July 29 1941,  
that I last saw her alive on July 29 1941,  
and that death occurred on the date and hour stated above.

8. AGE: Years 72 Months 4 Days 9  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Immediate cause of death Cerebral hemorrhage

Due to \_\_\_\_\_

Due to \_\_\_\_\_

9. Birthplace St. Louis Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business Home

Other conditions Cerebral hemorrhage  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

MOTHER FATHER

12. Name unknown

13. Birthplace unknown \_\_\_\_\_  
(City, town, or county) (State or foreign country)

14. Maiden name unknown

15. Birthplace unknown \_\_\_\_\_  
(City, town, or county) (State or foreign country)

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant Robert Lee Johnson

(b) Address 3104 Oneida

17. (a) Burial (b) Date thereof 8-24  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cabany

22. If death was due to external causes, fill in the following:

(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? \_\_\_\_\_

18. (a) Signature of funeral director O. W. Johnson

(b) Address 2829 Washington

19. (a) AUG - 1 1941 (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_  
(Specify type of place) (c) Means of injury

23. Signature Blair Hester (M. D. or other) \_\_\_\_\_  
Address 2425 Biddle Date signed 8/1/41

**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.....

*Oliver Wendell Johnson*

Licensed Embalmer No. 4190

P. O. Address 2829 Washington

**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, fact should be so stated above.**