

FILED APR 13 1942 791
Registration District No. _____

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1717 1/2 O'Fallon St
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 26yrs years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County 25 100 17 9
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 1717 1/2 O'Fallon St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country XXXXXXXX

3. (a) PRINT FULL NAME Katherine (Kate) Murphy

3. (b) If veteran, name war None 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 XXXXXX 6. (c) Age of husband or wife if alive XXXXXX years
7. Birth date of deceased June 16th. 1872
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
69 8 20 hr. min.

9. Birthplace Washington D.C.
(City, town, or county) (State or foreign country)

10. Usual occupation House Work

11. Industry or business At Home

12. Name Timothy Murphy
13. Birthplace Ireland
(City, town, or county) (State or foreign country)
14. Maiden name Mary Cushing
15. Birthplace Ireland
(City, town, or county) (State or foreign country)

16. (a) Informant Timothy Murphy
(b) Address 4671 Plam St
17. (a) Burial (b) Date thereof 3/31/42
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemt

18. (a) Signature of funeral director Harrigan & Sheatan Und Co
(b) Address 4415 Washington Blvd
19. (a) MAR 30 1942 (b) J. F. Preedock
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 28th.
year 1942 hour 9:00 AM minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____;
that I last saw h. _____ alive on _____ 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death
Coronary sclerosis
arteriosclerosis

Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death) 94a

Major findings: Of operations 94a
Of autopsy _____

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

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

23. Signature Janis P. [unclear] (M.D. or other) born
Address 1306 [unclear] care Date signed 3/30/42

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

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5-3

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..... *Homer H. Fritz*

Licensed Embalmer No..... *38820*

P.O. Address.....

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.