

S. No. 2
M-2-43
5-17-39
I X33697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED SEP 29 1943

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 2177

Registration District No. 317 Primary Registration District No. 3068

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Maplewood
(c) Name of hospital or institution: Radford Nursing Home, Oakview Terrace
(d) Length of stay: In hospital or institution 1 week
In this community 4 years, months or days

3. (a) PRINT FULL NAME Mary Murphy
3. (b) If veteran, name war No
3. (c) Social Security No. None

4. Sex female 5. Color or race white
6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife John Murphy
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Unkown

8. AGE: Years About 75 Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace Ireland
(City, town, or county) (State or foreign country)

10. Usual occupation Retired

11. Industry or business _____

MOTHER FATHER { 12. Name Tim Cowan
13. Birthplace Ireland
14. Maiden name Nora Gilmore
15. Birthplace Ireland

16. (a) Informant Nora Surkamp
(b) Address 1516 Kienlen Ave.

17. (a) Burial (b) Date thereof Sept. 29/43
(c) Place: burial or cremation Calvary Cem.

18. (a) Signature of funeral director Jos. W. Clark
(b) Address 1125 Monticourt Ave.

19. (a) SEP 28 1943 (b) [Signature]
(Date received local health) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County 000
(c) City or town St. Louis
(d) Street No. 2801 Park Ave.
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 26
year 1943 hour 6.30 minute A.M.
21. I hereby certify that I attended the deceased from Aug 20th
1943 to Sept 19 1943
that I last saw h. er alive on Sept 19 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Excess of Carcinoma of the stomach
Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Same as above
Of operations _____
Of autopsy _____

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

23. Signature [Signature] (M. D. or other) [Signature]
Address [Signature] Date signed 9/27/43

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

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

96
5
6

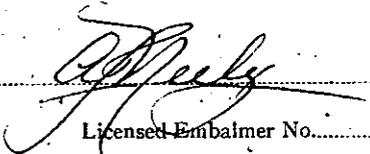
SEP 29 1943

Record Room
Desloge Hospital

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..... 

Licensed Embalmer No. 3225

P. O. Address..... 1125 Hodiamentave, m

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.