

FILED JUL 8 1944

318

Registration District No. \_\_\_\_\_

Primary Registration District No. L 1003

State File No. \_\_\_\_\_

Registrar's No. 5850

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:  
4429 Laclede Ave  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
 In this community \_\_\_\_\_  
 years, months or days

3. (a) PRINT FULL NAME James H. Murphy

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. 489-16-5235

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Aug. 22, 1864  
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>79</u>	<u>10</u>	<u>5</u>	hr. min.

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

10. Usual occupation At Home

11. Industry or business \_\_\_\_\_

12. Name Philip Murphy

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

14. Maiden name Honora Connors

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

16. (a) Informant Thomas F. Casey

(b) Address 4429 Laclede Ave

17. (a) Burial (b) Date thereof 6/30/44  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Stroot - Carroll

(b) Address 4600 Natural Bridge Ave

19. (a) JUN 29 1944 (Date received local registrar) J. F. Bedeak (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Mad  
 (c) City or town St. Louis (If outside city or town limits, write "RURAL")  
 (d) Street No. 4429 Laclede Ave (If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 27 year 1944 hour 1 minute 21 P. M.

21. I hereby certify that I attended the deceased from Jan. 1 - 1944 to June 27, 1944 that I last saw him alive on June 27 - 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Uterus - Sclerotic Hypertensiva  
Disease - Chronic Myocarditis

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

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

Other conditions (Include pregnancy within 3 months of death) 93

Major findings: 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? \_\_\_\_\_ (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) Means of injury \_\_\_\_\_

23. Signature U. J. Raymond (M. D. or other) Address 4340 West Pine St Date signed 6-28-44

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

2025 RELEASE UNDER E.O. 14176

**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

*Sheldon Collier*

Licensed Embalmer No.

*3382*

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**