

FILED OCT 13 1948

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29656

State File No.

Registration District No.

Primary Registration District No.

Registrar's No. 8503

1. PLACE OF DEATH:

(a) County

(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: Barnes Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 15 days (Specify whether
In this community 1 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

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

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

(d) Street No. 1121 Forest Ave
(If rural, give location)

(e) Citizen of foreign country? (Yes or No) No
If yes, name country

3. (a) PRINT FULL NAME ALBERTA CLARA GREEN MURPHY

3. (b) If veteran, name war 3. (c) Social Security No.

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

6. (b) Name of husband or wife George W. Murphy 6. (c) Age of husband or wife if alive years

7. Birth date of deceased June 15th, 1864
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>80</u>	<u>3</u>	<u>19</u>	hr. min.

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

10. Usual occupation At Home

11. Industry or business

MOTHER FATHER

12. Name David Smith

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

14. Maiden name Unknown Richsacker

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

16. (a) Informant Frank M. Green

(b) Address 1121 Forest Ave

17. (a) Removal (b) Date thereof 10/6/48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oregon Mo

18. (a) Signature of funeral director Robert J. Ambruster

(b) Address 6633 Clayton Road

19. (a) OCT 6 1948 (b) J. F. Bredeek
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 4 year 1944 hour 1 minute 35 P.M.

21. I hereby certify that I attended the deceased from SEPT. 19 1944 to OCT. 4 1944
that I last saw her alive on OCT. 4 1944
and that death occurred on the date and hour stated above.

Immediate cause of death: Bronchopneumonia

Due to Cerebral Vascular Accident

Due to Hypertension - cardio-vascular disease

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

Major findings: Of operations

Of autopsy as above

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 0

23. Signature Garnett F. Jagge (M. D. or other)

Address Barnes Hospital Date signed

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

644

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 Edward J. Bookland

Licensed Embalmer No. 2502

P. O. Address. Wester 7th

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.