

FILED NOV 1944  
818

State File No. \_\_\_\_\_  
Registrar's No. 8910

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

Primary Registration District No. 1003

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:  
Homer Phillips Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 9 days  
In this community 33 years  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME

Lillie Murphy

3. (b) If veteran, name war

3. (c) Social Security No.

name war --- No. None

4. Sex 3 Female 5. Color or race Negro 6. (a) Single, widowed, married, divorced Widow  
6. (b) Name of husband or wife Hezekiah 6. (c) Age of husband or wife if alive --- years  
7. Birth date of deceased Unavailable - 1866  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
Abt. 78 -- -- -- hr. -- min.

9. Birthplace Printice Co., Mississippi  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business ---

MOTHER FATHER

12. Name Burt Moorman  
13. Birthplace Unknown Mississippi  
(City, town, or county) (State or foreign country)  
14. Maiden name Fannie Brown  
15. Birthplace Unknown Mississippi  
(City, town, or county) (State or foreign country)

16. (a) Informant William H. Brooks  
(b) Address 1525 a Cora Avenue

17. (a) Burial (b) Date thereof 10/21/44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood Cemetery

18. (a) Signature of funeral director Charles J. Gates

(b) Address 4107 Finney Avenue

19. (a) OCT 20 1944 (b) J. F. Bredek  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town St. Louis,  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2624 Stoddard  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country ---

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 19,  
year 1944 hour 11 minute 25 A. M.

21. I hereby certify that I attended the deceased from October 10, 1944, to October 19, 1944;  
that I last saw her alive on October 19, 1944;  
and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerotic Heart Disease Duration Unk.

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

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

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

Major findings: Of operations \_\_\_\_\_

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

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 Alvin Mason (M. D. or other) \_\_\_\_\_

Address 2601 Whittier Date signed 10/20/44

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

**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.....

..... Thomas J. Gates ....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....  .....

Licensed Embalmer No..... 4259 .....

P. O. Address..... 4107 Finney Avenue .....

**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.**