

FILED MAR 26 1945

Registration District No. _____

Primary Registration District No. **3063**

Registrar's No. **659**

1. PLACE OF DEATH:

(a) County **St. Louis**
(b) City or town **Clayton**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **St. Louis County Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **79 days**
(Specify whether years, months or days) **9 mos.**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Louis**
(c) City or town **University City**
(If outside city or town limits, write "RURAL")
(d) Street No. **1266 Purcell**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Charles A. Murphy

3. (b) If veteran, name war **None**

3. (c) Social Security No. **None**

4. Sex **M** 5. Color or race **W**

6. (a) Single, widowed, married, divorced **Single**

6. (b) Name of husband or wife **None**

6. (c) Age of husband or wife if alive **None** years

7. Birth date of deceased **May 1 1865**
(Month) (Day) (Year)

8. AGE: Years **79** Months **10** Days **9**
If less than one day hr. min.

9. Birthplace **New York N.Y.**
(City, town, or county) (State or foreign country)

10. Usual occupation **None**

11. Industry or business **None**

12. Name **John C. Murphy**

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

14. Maiden name **Mary Jane Campbell**

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

16. (a) Informant **Samuel W. Murphy**

(b) Address **1266 Purcell**

17. (a) **Burial** (b) Date thereof **3-13-1945**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. Peter's Cemetery**

18. (a) Signature of funeral director **Geo. L. Pleitach Inc.**

(b) Address **5966-68 Eastern Avenue**

19. (a) **MAR 12 1945** (b) **E. G. McCarroll, M.D.**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **10th**
year **1945** hour **12** minute **30 P.M.**

21. I hereby certify that I attended the deceased from **Dec. 21 1944** to **Mar. 10 1945**

that I last saw him alive on **Mar. 10 1945**

and that death occurred on the date and hour stated above.

Immediate cause of death **arterio-sclerotic heart disease**

Duration

Due to _____

Due to _____

Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations **g 2nd**

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 **W. H. Lewis** (M. D. or other)

Address **St. Louis Co. Hosp.** Date signed **3-10-45**

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

MOTHER, FATHER

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.....

Ben E. Hoffman

Licensed Embalmer No.....

4366

P. O. Address.....

St. Louis, Mo.

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.