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5-17-39
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FILED AUG 11 1945
318

Registrar's No. **6944**

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:
(a) County _____
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis City Hospital - Max C. Starkloff Memorial
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 days
(Specify whether _____)
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MO (b) County 060
(c) City or town ST Louis 17 25
(If outside city or town limits, write "RURAL")
Street No. Major ST A 9 9th Clifton
(If rural, give location)
(d) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Francis Matthew Murphy
3. (b) If veteran, name war _____ **3. (c) Social Security** No. _____

4. Sex MALE **5. Color or race** WHITE
6. (a) Single, widowed, married, divorced 2
6. (b) Name of husband or wife _____ **6. (c) Age of husband or wife if alive** _____ years

7. Birth date of deceased. _____ (Month) _____ (Day) _____ (Year)
8. AGE Years abt - 64 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation TAVERN PORTER

11. Industry or business _____

12. Name ARCHIBALD MURPHY

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

14. Maiden name MARGARET - UNKNOWN

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

16. (a) Informant St Vincent De Paul Society

(b) Address 2335 MULLAMPHY

17. (a) Burial (b) Date thereof AUG 7 1945
(Burial, cremation, or removal) _____ (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY

18. (a) Signature of funeral director Bullen Kelly

(b) Address 4386 S. 4th St. - Branch

19. (a) AUG 1945 (Date received local registrar) **(b)** g. j. Branch (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 1st
year 1945 hour 12:55 minute _____ P. M.
21. I hereby certify that I attended the deceased from July 27, 1945
_____, 19____, to Aug. 1st, 1945;
that I last saw him alive on Aug. 1st, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Anemia / 1 wk.
Duration _____

Due to _____
Due to _____

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

Major findings:
Of operations _____
Of autopsy 132
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? _____

(Specify type of place) _____
While at work? _____
23. Signature R. H. Stubbins (M. D.) 23052
Address 1515 Lafayette 8/1/45 signed _____

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..... *James A. Lammers*

Licensed Embalmer No..... *4142*

P. O. Address..... *St. Louis*

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.

Registration District No. 318

Primary Registration District No. 1003

AUG 13 1945

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: _____
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME Francis M. Murphy

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

4. Sex M 5. Color or race W

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

7. Birth date of deceased _____
(Month) (Day) (Year)

8. AGE: all 64 Years Months Days If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) AUG 20 1945 (b) J. F. Bredek
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____
 Year 1945 Hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;
 that I last saw him _____, 19____,
 and that death occurred on the date and hour stated above.
 Immediate cause of death _____

Due to _____

Due to _____

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

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?
(Specify type of place)

While at work? _____ (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

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

MOTHER FATHER

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

1945

S-22358