V. S. No. 2
00M—5-43
Rev. 5-17-39
No. I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 25975

FILED SEP 7 1945

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7569

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

1. PLACE OF DEATH:
(a) County St. Louis.
(b) City or town (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 4057 Lincoln
(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

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County
(c) City or town St. Louis. (If outside city or town limits, write "RURAL")
(d) Street No. 4057 Lincoln. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Mary 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 Married.
6. (b) Name of husband or wife William Murphy.
6. (c) Age of husband or wife if alive years
7. Birth date of deceased May 1, 1880. (Month) (Day) (Year)
8. AGE: Years 65 Months 3 Days 28 If less than one day hr. min.
9. Birthplace Ireland. (City, town, or county) 4 (State or foreign country)
10. Usual occupation Housewife
11. Industry or business
MOTHER FATHER
12. Name Dennis Whelan.
13. Birthplace Ireland. (City, town, or county) (State or foreign country)
14. Maiden name Mary Maher
15. Birthplace Ireland. (City, town, or county) (State or foreign country)
16. (a) Informant William Murphy
(b) Address 4057 Lincoln
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 31 1945 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery.
18. (a) Signature of funeral director Gerard Quinn
(b) Address 1389 Union Blvd.
19. (a) AUG 30 1945 (Date received by local registrar) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 28 year 1945 hour 9 minute 44 A.M.
21. I hereby certify that I attended the deceased from Nov 30, 1944, to Aug 28, 1945, that I last saw her alive on Aug 28 1945 and that death occurred on the date and hour stated above.

Duration

Immediate cause of death Cerebral Hemorrhage
Due to Hypertension (250-120)
Due to Chronic Nephritis
Other conditions (Include pregnancy within 3 months of death)

PHYSICIAN

Major findings:
Of operations
Of autopsy 93 d

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? (e) Means of injury

23. Signature W. H. White M.D. (M. D. or other)
Address 8032 N. Lindbergh Date signed 8-29-45

(Licensed Embalmer's Statement on Reverse Side)

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 Ronald Jahnke

Licensed Embalmer No. 3917

P. O. Address .....

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.