DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 7 1945

Registration District No. 42

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 36677

Primary Registration District No. 1000

Registrar's No. 1252

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

1. PLACE OF DEATH:

(a) County: Buchanan

(b) City or town: St. Joseph
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Joseph's Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 Mo. (Specify whether years, months or days)

In this community 65 Years

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri. (b) County: Buchanan

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

(d) Street No. 10th & Powell (St. Joseph's Hosp't.
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME: Sister Aloysia Murphy

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

3. (c) Social Security No. None

4. Sex: Female

5. Color or race: White

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

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

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

7. Birth date of deceased: September (Month) 16 (Day) 1855 (Year)

8. AGE: Years 90 Months 2 Days 3 If less than one day hr. min.

9. Birthplace: Roxbury (City, town, or county) Mass. (State or foreign country)

10. Usual occupation: Retired Religious

11. Industry or business: St. Joseph's Hospital

FATHER
12. Name: Daniel Murphy
13. Birthplace: Unknown (City, town, or county) Ireland (State or foreign country)

MOTHER
14. Maiden name: Mary Collenes
15. Birthplace: Unknown (City, town, or county) Ireland (State or foreign country)

16. (a) Informant: Sister Catherine
(b) Address: 10th. & Powell, St. Joseph's Hospital

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Nov. 21, 1945 (Month) (Day) (Year)
(c) Place: burial or cremation: Mt. Olivet Cemetery

18. (a) Signature of funeral director: Herman W. Schulsder
(b) Address: 1802 Union St. St. Joseph, Mo.

19. (a) Nov 22 1945 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 19 year 1945 hour 11 minute 50 A.M.

21. I hereby certify that I attended the deceased from 7-7, 1942, to 11-19, 1945, that I last saw her alive on 11-19, 1945, and that death occurred on the date and hour stated above.

Immediate cause of death: Coronary Occlusion — Duration: died suddenly

Due to:

Due to: Arteriosclerosis, general — unknown

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

Major findings:
Of operations:
Of autopsy: 946

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature: [illegible] M. D. or other

Address: [illegible] Date signed: 11-20-45

1428 (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~~ Elmer Thomas, Registered Apprentice No. ....., working under my personal supervision.

Signed Elmer Thomas

Licensed Embalmer No. 2640

P. O. Address St. Joseph 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.