

U. S. No. 2  
DOM-2-43  
Rev. 5-17-39  
I X35697

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

11480

State File No. \_\_\_\_\_

**FILED** MAR 30 1946  
318

Primary Registration District No. **1003**

Registrar's No. **2145**

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:  
Homer G Phillips Hospital  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 88 days  
(Specify whether)  
 In this community \_\_\_\_\_  
years, months or days

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. 2800 Arsenal St  
(If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Earl Murphy  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month Mar. day 2  
 year 1946 hour 10 minute 45 A. M.

4. Sex Male 5. Color or race Col 6. (a) Single, widowed, married, divorced Single  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased: Oct. 20 1906  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 12-20, 1945, to 3-2, 1946;  
 that I last saw him in alive on 3-2, 1946  
 and that death occurred on the date and hour stated above.

8. AGE: Years 39 Months 4 Days 12 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death: Actinomycoses with probable Lung's  
~~Unk~~ Unk

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

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions None  
(Include pregnancy within 3 months of death)

10. Usual occupation Laborer

11. Industry or business \_\_\_\_\_

Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy Yes

12. Name Thornton Murphy  
 13. Birthplace Missouri  
(City, town, or county) (State or foreign country)  
 14. Maiden name Lydia Ashley  
 15. Birthplace Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Frank Cook  
 (b) Address 4253 Aldine

17. (a) burial (b) Date thereof 3-5-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood

18. (a) Signature of funeral director Raymond B...  
 (b) Address 3784 Timber Dr.

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? \_\_\_\_\_

19. (a) 5 1946 (b) J. F. Bredeek  
(M.D. or other) (Registrar's signature)

While at work? \_\_\_\_\_  
(Specify type of place) (e) Means of injury  
 23. Signature O. J. Ayer (M. D. or other)  
 Address 2601 N Whitier Date signed 3/5/46

10392 WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

*This body was not embalmed*

Registered / Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

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.**