

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

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

**FILED** APR 18 1946  
Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 3238

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:  
2705 1/2 Caroline Street /  
(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) 6 years

In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 00

(c) City or town St. Louis  
(If outside city or town limits, write "RURAL") 22

(d) Street No. 2705 1/2 Caroline St.  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 0

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Joseph LaMont Murphy

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex M 5. Color or race W

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

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased December 24 1874  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 4th  
year 1946 hour 9:30 minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from April 1946  
\_\_\_\_\_, 19\_\_\_\_, to April 4 1946

that I last saw him alive on 4-4-46  
and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>71</u>	<u>3</u>	<u>10</u>	hr. _____ min. _____

Immediate cause of death Coronary Occlusion

Due to Arteriosclerosis

Due to Hypertension

Other conditions 94  
(Include pregnancy within 3 months of death)

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

10. Usual occupation Merchant

11. Industry or business Self

Major findings:  
Of operations no

Of autopsy no

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

MOTHER FATHER

12. Name James K. Murphy

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

14. Maiden name Mary Bartle

15. Birthplace Franklin County, Missouri  
(City, town, or county) (State or foreign country)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) no

(b) Date of occurrence no

(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 \_\_\_\_\_

Signature B. Shaubler (M. D. or other) 0

Address 1544 S. Jefferson Date signed 4/6/46

16. (a) Informant Louella Murphy

(b) Address 2705 1/2 Caroline St.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-8-46  
(Month) (Day) (Year)

(c) Place: burial or cremation St. Clair, Mo.

18. (a) Signature of funeral director A. W. McLaughlin

(b) Address 2301 Lafayette Avenue

19. (a) APR 8 1946 (Date received local registrar)

J. F. Bredek Registrar's signature

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

13348

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**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..... *E W Cooper* .....

Licensed Embalmer No. *3830* .....

P. O. Address *2301 Lafayette Ave* .....

**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.**