

10799  
FILED AUG 9 1946  
Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 6562

1. PLACE OF DEATH:

(a) County.....

(b) City or town..... **St. Louis, Mo.**  
(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.....  
(Specify whether)

In this community.....  
years, months or days

3. (a) PRINT FULL NAME **JOHN MURPHY**

3. (b) If veteran, name war..... **No**

3. (c) Social Security No. **498-16-7982**

4. Sex **Male** 5. Color or race **White**

6. (a) Single, widowed, married, divorced **Widower**

6. (b) Name of husband or wife **Mary Murphy**

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

7. Birth date of deceased..... **September 15 1884**  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

**61 10 9** hr. min.

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

10. Usual occupation **Laborer**

11. Industry or business **Plumbers Helper**

12. Name **James Murphy**

13. Birthplace **Ireland 4**  
(City, town, or county) (State or foreign country)

14. Maiden name **Bridget Egan**

15. Birthplace **Ireland 4**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Peter White**

(b) Address **2628a Montgomery St.**

17. (a) **Burial** (b) Date thereof **17-27-46**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cemetery**

18. (a) Signature of funeral director **Cullinane Bros.**

(b) Address **3320 N. Kingshighway Blvd.**

19. (a) **JUL 26 1946** **J. F. Bredebeck**  
(Date received local registrar) (Registrar's signature)

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. **2628a Montgomery St.**  
(If rural, give location)

(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **24**  
year **1946** hour **10:50** minute **P** M.

21. I hereby certify that I attended the deceased from **June 15**  
19 **46** to **July 24** 19 **46**  
that I last saw him **in** alive on **July 24** 19 **46**  
and that death occurred on the date and hour stated above.

Immediate cause of death: **Cardiac failure**  
**No definite disease of heart**

Due to **hypertension**

Due to **Prostate hypertrophy**

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

Major findings: **resection for Prostate hypertrophy**

Of operations.....

Of autopsy.....

Duration **4 days**

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?.....

While at work?..... (Specify type of place)

(e) Means of injury.....

23. Signature **E. J. Carson, M.D.** (M.D. or other)

Address **1515 Lafayette Avenue** Date signed **7/25/46**

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

**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.....

*Fred Trick*

Licensed Embalmer No.....**3186**.....

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