

S. No. 2
M-5-43
v. 5-17-39
I X36671

35442

DEPARTMENT OF HEALTH
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED OCT 16 1946
318

1003

Registrar's No. 8615

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County St. Louis

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

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

(d) Length of stay: In hospital or institution 2-months
(Specify whether _____)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County foo

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

(d) Street No. 325 N. Newstead Ave.
(If rural, give location)

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

3. (a) PRINT FULL NAME Mary F. Murphy

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F. 5. Color or race W. 6. (a) Single, widowed, married, divorced S.

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

7. Birth date of deceased Nov. 2nd., 1860
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 6th. year 1946 hour 5 minute a. M.

21. I hereby certify that I attended the deceased from August 7 1946, to October 2 1946
that I last saw her alive on October 5 1946
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
<input checked="" type="checkbox"/>	<u>85</u>	<u>11</u>	<u>4</u>	hr. _____ min. _____

Immediate cause of death: Cancer metastasis to liver with liver and heart failure Duration 5 days

Due to Cancer of sigmoid 17 months

Due to _____

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

11. Industry or business _____

12. Name William Murphy

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

14. Maiden name Mary Flynn

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

16. (a) Informant Mrs. Florence Mckinlay
(b) Address 125 Edgar Road

17. (a) Burial (b) Date thereof 10-9-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director Arthur J. Hannell
(b) Address 3840 Lindell Blvd.

19. (a) OCT 7 1946 (b) J. J. Bredesek
(Date received local registrar) (Registrar's signature)

PHYSICIAN _____

Major findings: Inoperable cancer of sigmoid colon

Of operations _____

Of autopsy _____

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 Artis A. Freyer (M. D. or other) _____
Address 235 3rd Bldg Date signed 10/2/46

(Licensed Embalmer's Statement on Reverse Side)

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

34264

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 Stanley Marshall

Licensed Embalmer No. 2868

P. O. Address 3840 Lindell

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.