

7. S. No. 2
FORM-2-43
Rev. 5-17-39
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22992

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED JUL 7 1947

Registration District No. 317

Primary Registration District No. 6076

Registrar's No. 1419

1. PLACE OF DEATH:

(a) County ST. LOUIS
(b) City or town ST. JOHNS STATION
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
3361 Brown Road
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 3.36 years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County ST LOUIS 96
(c) City or town ST. JOHNS STATION
(If outside city or town limits, write "RURAL")
(d) Street No. 3361 BROWN ROAD
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

NELLIE MURPHY

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 30
year 1947 hour 3:30 minute a. M.

21. I hereby certify that I attended the deceased from 2/1
1945 to June 30 1945;
that I last saw her alive on June 29 1945
and that death occurred on the date and hour stated above.

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex FEMALE 5. Color or race WHITE 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: AUG. 5 1961
(Month) (Day) (Year)

8. AGE: Years 85 Months 10 Days 25 If less than one day: hr. _____ min. _____

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

10. Usual occupation AT HOME

11. Industry or business _____

12. Name JOHN MURPHY 9

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

14. Maiden name _____

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

16. (a) Informant H. A. Schneider

(b) Address 6104 Boston Ave.

17. (a) BURIAL (b) Date thereof 7/2/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cem.

18. (a) Signature of funeral director W. M. Miller and Co.

(b) Address 5165 Delmar Blvd.

19. (a) 7-3-47 (b) W. M. Miller
(Date received local registrar) (Registrar's signature)

Immediate cause of death: myocardial infarction

Due to Hypertensive-Cardiovascular disease

Vascular disease

Due to arteriosclerosis

senile changes

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

Major findings: 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 W. M. Miller (M. D. or other) MO

Address 4957 Maryland Date signed 6/30/47

Dr Pranger

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

96000

1938-11-14

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 *H. Y. Jarvis*

Licensed Embalmer No. *3384*

P. O. Address *St. Louis*

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.