

FILED SEP 23 1947

Registration District No. 278

Primary Registration District No. 5947

Registrar's No. 54

1. PLACE OF DEATH: Phelps
 (a) County
 (b) City or town St. James, Mo
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Soldiers Home Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2 years
 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County Phelps
 (c) City or town St. James
 (If outside city or town limits, write "RURAL")
 (d) Street No.
 (If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Mattie R. Murphy
 (b) If veteran, name war
 (c) Social Security No. _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month 8 day 19
 year 1947 hour 6:45 am minute _____ M.
 21. I hereby certify that I attended the deceased from Oct 20 1945 to 8-19-1947
 that I last saw her alive on 8-18-47 1947
 and that death occurred on the date and hour stated above.
 Immediate cause of death: Cerebral Embolus Duration 4 days

4. Sex F 5. Color or race W
 6. (a) Single, widowed, married, divorced, widowed
 (b) Name of husband or wife Emmet Murphy
 6. (c) Age of husband or wife if alive _____ years
 (Month) (Day) (Year)

Due to: Heart disease 2 yrs
 Due to: _____
 Other conditions: _____
 (Include pregnancy within 3 months of death) 83 B
 Major findings: _____
 Of operations: _____
 Of autopsy: _____

8. AGE: Years 64 Months 4 Days 29
 If less than one day hr. _____ min. _____

9. Birthplace Jackson Co Mo
 (City, town, or county) (State or foreign country)

10. Usual occupation House Wife

11. Industry or business _____

12. Name Don't Know 9

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

14. Maiden name _____
 (City, town, or county) (State or foreign country)

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

16. (a) Informant Soldiers Home Office

(b) Address St. James Mo

17. (a) Burial (b) Date thereof 8-22-47
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Camden Mo

18. (a) Signature of funeral director Grace Dickler
 (b) Address St. James Mo

19. (a) 8-19-47 (b) Date received local registrar
 (Date received local registrar) (Registrar's signature)

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?

 (Specify type of place) _____
 While at work (c) Means of injury _____
 23. Signature William H. Greaves M.D. or other M.D.
 Address St. James Date signed 8-19-47

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

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.....

me....., Registered Apprentice No.....
working under my personal supervision.

Signed *Oral E Licklieb*.....

Licensed Embalmer No. *2546*.....

P. O. Address *St James 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.