

FILED OCT 7 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 32041

318

1003

7947

BIRTH NO.		REG. DIST. NO.		PRIMARY REG. DIST. NO.		Registrar's No.			
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE				b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST LOUIS				c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST LOUIS					
c. LENGTH OF STAY (In this place) 10 weeks				d. STREET ADDRESS (If rural, give location) 4914 Laclede					
d. FULL NAME OF HOSPITAL OR INSTITUTION ST JOHN'S HOSPITAL									
3. NAME OF DECEASED (Type or Print) a. (First) MARK			b. (Middle)			c. (Last) MURPHY			
4. DATE OF DEATH (Month) (Day) (Year) SEPT 12-1949			5. SEX FEMALE			6. COLOR OR RACE WHITE			
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED			8. DATE OF BIRTH SEPT 3, 1867			9. AGE (In years last birthday) 82			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) MEMPHIS TENN			
12. CITIZEN OF WHAT COUNTRY?			13a. FATHER'S NAME MICHAEL CARRIGAN			13b. MOTHER'S MAIDEN NAME BRIDGET RICHARDSON			
14. NAME OF HUSBAND OR WIFE CHAS E MURPHY			15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.			
17. INFORMANT'S SIGNATURE OR NAME J. Frank Walsh			18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Fracture of left femur ANTECEDENT CAUSES Morbidity of any kind due to (b) rise to the above cause (a) without the underlying cause last. DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Terminal Pneumonia			19. INTERVAL BETWEEN ONSET AND DEATH 59040 21			
19a. DATE OF OPERATION 6/12/49			19b. MAJOR FINDINGS OF OPERATION Fractured femur - nailed			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident			21b. PLACE OF INJURY (e.g., in or about home, factory, street, office bldg., etc.) Home			21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) St. Louis Mo. 1949			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) July 6 49 10:4			21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21f. HOW DID INJURY OCCUR? fell in home sleeping porch			
22. I hereby certify that I attended the deceased from 6-12, 1949, to 9-12, 1949, and that death occurred at 40 m., from the causes and on the date stated above.									
23a. SIGNATURE Samuel X. Sullivan M.D.			23b. ADDRESS St. John's Hospital			23c. DATE SIGNED 9-13-49			
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			24b. DATE 9-14-49			24c. NAME OF CEMETERY OR CREMATORY CALVARY			
24d. LOCATION (City, town, or county) (State) ST LOUIS MO.			DATE REC'D BY LOCAL REG. SEP 14 1949			REGISTRAR'S SIGNATURE B. Casater			
25. FUNERAL DIRECTOR'S SIGNATURE Sullivan-Kelly			ADDRESS 4386 Lindell						

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

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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.....

..... Student Embalmer No. ....

working under my personal supervision.

Student .....  
Student Embalmer

Signed.....

*James A. Lammers*

Licensed Embalmer No. 4142

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.**