

FILED OCT 19 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

35923

State File No. ....

BIRTH NO. ....		REG. DIST. NO. <u>317</u>		PRIMARY REG. DIST. NO. <u>4465</u>		Registrar's No. <u>4064</u>	
1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MO</u> b. COUNTY <u>ST. LOUIS</u> a. 96			
b. CITY (If outside corporate limits, write RURAL and give town or township) <u>ROCK HILL</u>		c. LENGTH OF STAY (In this place) <u>24 yrs.</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>ROCK HILL</u> 14		3	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>611 N. ROCK HILL ROAD.</u>				d. STREET ADDRESS (If rural, give location) <u>611 N. ROCK HILL ROAD.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>WALTER LAWRENCE</u> b. (Middle) <u>MURPHY</u> c. (Last) <u>MURPHY</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>OCT. 1<sup>st</sup> 1949</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>JUNE 29<sup>th</sup> 1888</u>		9. AGE (In years last birthday) <u>61</u>	IF UNDER 1 YEAR Months Days	IF UNDER 2 WRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ASST. MANAGER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MUNDET CORK CO</u>		11. BIRTHPLACE (State or foreign country) <u>N. Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>JOHN MURPHY</u>		13b. MOTHER'S MAIDEN NAME <u>DELIA NIEDA</u>		14. NAME OF HUSBAND OR WIFE <u>HELEN MURPHY</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>492-10-0413</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs Helen Murphy - 611 N. Rock Hill Rd.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Thrombosis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 years</u>  <u>4201</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>420.1</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>was</u> <u>1948</u> , to <u>Oct. 1</u> , 1949, that I last saw the deceased alive on <u>Oct. 1, 1949</u> , and that death occurred at <u>9:30 A. M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>D. J. Volkmann M.D.</u>				23b. ADDRESS <u>532 W. Big Bend</u>		23c. DATE SIGNED <u>10/1/49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>Oct. 4<sup>th</sup> 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>RESURRECTION CEM</u>		24d. LOCATION (City, town, or county) (State) <u>ST. LOUIS MO</u>	
DATE REC'D BY LOCAL REG. <u>10-3-49</u>		REGISTRAR'S SIGNATURE <u>Walter S. Woube M.D.</u>		5. FUNERAL DIRECTOR'S SIGNATURE <u>L. Muller M.D. &amp; Co. Delmar</u>		ADDRESS <u>5165</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

19-802

NOV 7 1949

OCT 27 1949

2-477

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.

Signed \_\_\_\_\_

*J. G. Farris*

Signed \_\_\_\_\_  
Student Embalmer

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.