

FILED JAN 26 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 2837

REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

Registrar's No. 450

2009
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 450	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give OR TOWN St. Louis, Mo		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis		2239	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital # 1				d. STREET ADDRESS (If rural, give location) 23 920a Geyer Avenue			
3. NAME OF DECEASED (Type or Print) CORA		a. (First)		b. (Middle)		c. (Last) MURPHY	
5. SEX F		6. COLOR OR RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced		4. DATE OF DEATH 1 (Month) 12 (Day) 50 (Year)	
9. AGE (in years last birthday) 69		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife		10b. KIND OF BUSINESS OR INDUSTRY _____		8. DATE OF BIRTH July 11-1880	
11. BIRTHPLACE (State or foreign country) Hazelhurst, Mississippi		12. CITIZEN OF WHAT COUNTRY? _____		13a. FATHER'S NAME William Conn		13b. MOTHER'S MAIDEN NAME Elizabeth Scott	
14. NAME OF HUSBAND OR WIFE William		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME Helen Chromoga 1510 Menard Street	
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension 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 1 day 5 1/2	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				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) _____		331A	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ m.		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 April 2, 1950, to Jan 12, 1950, that I last saw the deceased alive on Jan 12, 1950, and that death occurred at 2:15 P.m., from the causes and on the date stated above.							
23a. SIGNATURE H. Leonard J. Nash		23b. ADDRESS 0.0. 1829 S. 18 St		23c. DATE SIGNED 1/12/50			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 1-16-50		24c. NAME OF CEMETERY OR CREMATORY Mount Hope		24d. LOCATION (City, town, or county) St. Louis County, Missouri (State) _____	
DATE REC'D BY LOCAL REG. JAN 16 1950		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR'S SIGNATURE McLaughlin Funeral Home Inc. 2301 W. Lafayette		ADDRESS _____	

2025

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 L R Cooper

Licensed Embalmer No. 3633

P. O. Address 2501 Lafayette

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.