

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

18351
State File No. 4560
Registrar's No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH
a. COUNTY _____

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE **MO**
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** **2059**

d. FULL NAME OF HOSPITAL OR INSTITUTION: **5824th WESTMINSTER**

d. STREET ADDRESS (If rural, give location) **5824th WESTMINSTER**

3. NAME OF DECEASED
a. (First) **RUTH** b. (Middle) **MARIE** c. (Last) **MURPHY** 4. DATE OF DEATH (Month) (Day) (Year) **MAY 15-1952**

5. SEX **FEMALE** 6. COLOR OR RACE **WHITE** 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) **SINGLE** 8. DATE OF BIRTH **APRIL 7-1930** 9. AGE (In years last birthday) **22** UNDER 1 YEAR UNDER 1 MONTH UNDER 1 HOUR

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **AT HOME**

10b. KIND OF BUSINESS OR INDUSTRY _____

11. BIRTHPLACE (State or foreign country) **ST. LOUIS, MO**

12. CITIZEN OF WHAT COUNTRY? **U**

13a. FATHER'S NAME **JOSEPH MURPHY**

13b. MOTHER'S MAIDEN NAME **EVELYN KOESSLER**

14. NAME OF HUSBAND OR WIFE _____

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____

16. SOCIAL SECURITY NO. _____

17. INFORMANT'S SIGNATURE OR NAME **Joseph Murphy - 5824th Westminster Pl** ADDRESS _____

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) **Spontaneous rupture of spleen**
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (a) _____
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.

19a. DATE OF OPERATION _____

19b. MAJOR FINDINGS OF OPERATION _____

20. AUTOPSY? YES NO

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) (m.) _____

21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR? **0202**

22. I hereby certify that I attended the deceased from **May 17**, 19**52**, to **May 11**, 19**52**, that I last saw the deceased alive on **May 11**, 19**52**, and that death occurred at **6 A.** m., from the causes and on the date stated above.

23a. SIGNATURE **H. S. Pyne** (Degree or title) _____

23b. ADDRESS **2752nd Cherokee**

23c. DATE SIGNED **5-16-52**

24a. BURIAL, CREMATION, REMOVAL (Specify) **BURIAL**

24b. DATE **MAY 17-1952**

24c. NAME OF CEMETERY OR CREMATORY **S. S. PETER & PAUL'S CEM.**

24d. LOCATION (City, town, or county) (State) **ST. LOUIS MO**

DATE RECD BY LOCAL HEALTH DEPT. **MAY 16 1952**

REGISTRAR'S SIGNATURE **Carl Smith MD**

25. FUNERAL DIRECTOR'S SIGNATURE **L. MOLLEN UND., Co., 5165 DELMAR** ADDRESS _____

WRITE PLAINLY—USING UNFAADING 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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

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.