

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **15511**  
Registrar's No. **3750**

FILED APR 23 1953

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. <b>3750</b>		
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY _____				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN <b>St. Louis</b>		d. Is Residence within limits of a city incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Alexian Bros. Hospital</b>				e. STREET ADDRESS (If rural, give location) <b>19 4353 McPherson 2199</b>				
3. NAME OF DECEASED (Type or Print) a. (First) <b>Leslie</b> b. (Middle) <b>Michael</b> c. (Last) <b>Brophy</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>April 7, 1953</b>					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>March 29, 1888</b>		9. AGE (In years last birthday) <b>65</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Showman</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Show Business</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13a. FATHER'S NAME <b>John Brophy</b>			13b. MOTHER'S MAIDEN NAME <b>Catherine Miller</b>		14. NAME OF HUSBAND OR WIFE <b>Darlene</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Darlene Brophy</b> ADDRESS <b>4353 McPherson</b>			
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, asphyxia, etc. It means the disease, injury, or complication which caused death.				I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Pulmonary Carcinoma</b>  ANTECEDENT CAUSES <b>Bronchogenic Carcinoma</b> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <b>4 hrs</b>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.								
19a. DATE OF OPERATION <b>2/26/53</b>		19b. MAJOR FINDINGS OF OPERATION <b>Bronchoscopy only</b>				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) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>162 X</b>				
22. I hereby certify that I attended the deceased from <b>1/16, 1953</b> , to <b>4/7, 1953</b> , that I last saw the deceased alive on <b>4/6, 1953</b> and that death occurred at <b>11:35a.</b> , from the causes and on the date stated above.								
23a. SIGNATURE <b>George S. McMan</b> (Degree or title) <b>MD</b>				23b. ADDRESS <b>3903 Olive St. Mo.</b>		23c. DATE SIGNED <b>4/7/53</b>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>4-10-53</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Calvary</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>			
DATE REC'D BY LOCAL REG. <b>APR 9 1953</b>		REGISTRAR'S SIGNATURE <b>J. Earl Smith M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Albert H. Hoppe</b> ADDRESS <b>4700 Washington Blvd.</b>				

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.....  
Signature of Student Embalmer

Signed *Robert M. Murray*

Licensed Embalmer No. *3749*

P. O. Address *St. Louis, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.