

FILED DEC 17 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 42659

BIRTH NO. _____		REG. DIST. NO. <u>318</u>		PRIMARY REG. DIST. NO. <u>1003</u>		Registrar's No. <u>11130</u>							
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Illinois</u> b. COUNTY _____									
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis, Missouri</u>		c. LENGTH OF STAY (In this place) <u>2 Days</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Quincy</u>		<u>8/20</u>							
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Barnes Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>Hillcrest Home</u>									
3. NAME OF DECEASED (Type or Print) a. (First) <u>Ray</u> b. (Middle) <u>E</u> c. (Last) <u>Murphy</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>December 5, 1954</u>										
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>divorced</u>	8. DATE OF BIRTH <u>12-9-1901</u>		9. AGE (In years last birthday) <u>52</u>	<table border="1"> <tr> <td># UNDER 1 YEAR</td> <td># UNDER 1 HR.</td> </tr> <tr> <td>Months _____</td> <td>Days _____</td> </tr> <tr> <td>Hours _____</td> <td>Mins. _____</td> </tr> </table>	# UNDER 1 YEAR	# UNDER 1 HR.	Months _____	Days _____	Hours _____	Mins. _____
# UNDER 1 YEAR	# UNDER 1 HR.												
Months _____	Days _____												
Hours _____	Mins. _____												
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>freight agent</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Curlington RR</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Mass.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>						
13a. FATHER'S NAME <u>Edward Murphy</u>			13b. MOTHER'S MAIDEN NAME <u>Mary Mealey</u>		14. NAME OF HUSBAND OR WIFE <u>unknown</u>								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>unk.</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. A. Thomas, Aurora, Ill.</u>									
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute myocardial infarction</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>advanced coronary arteriosclerosis</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u> <u>Pulmonary tuberculosis</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>4 years</u> <u>2 years</u>						
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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? <u>42018</u>											
22. I hereby certify that I attended the deceased from <u>12/3</u> , 19 <u>54</u> , to <u>12/5</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>12/5</u> , 19 <u>54</u> , and that death occurred at <u>1:10p.m.</u> , from the causes and on the date stated above.													
23a. SIGNATURE <u>FR Bradley MD</u> (Degree or title)				23b. ADDRESS <u>Barnes Hospital</u>		23c. DATE SIGNED <u>DEC 6 1954</u>							
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>		24b. DATE <u>12-6-54</u>	24c. NAME OF CEMETERY OR CREMATORY _____		24d. LOCATION (City, town, or county) (State) <u>Aurora, Ill.</u>								
DATE REC'D BY LOCAL REG. <u>DEC 6 1954</u>		REGISTRAR'S SIGNATURE <u>Carl Smith MD</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Corcoran, Aurora, Ill.</u>									

WRITE PLAINLY—USING UNFADING 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.....

John Allen Davis
.....
Licensed Embalmer No. *4058*
.....
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.