

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED NOV 18 1955

State File No. **38669**
Registrar's No. **9749**

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

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|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY | |
| b. CITY OR TOWN St. Louis | c. LENGTH OF STAY (In this place) 1 wk | c. CITY OR TOWN St. Louis | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/> |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Behrman Hosp | | e. STREET ADDRESS (If rural, give location) 18 4567 Ave | |

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|-------------------------------------|---------------------------|-------------|-------------------------|---------------------------------------|
| 3. NAME OF DECEASED (Type or Print) | a. (First) Michael | b. (Middle) | c. (Last) Murphy | 4. DATE OF DEATH (Month) (Day) (Year) |
| | | | | Nov. 6, 1955 |

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|-----------------|---------------------------|--|----------------------------------|---|---|---|
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH 4/4/1884 | 9. AGE (In years last birthday) 71 | IF UNDER 1 YEAR Months 6 Days 2 | IF UNDER 2 WKS. Hours Mins. |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) stationary engineer | 10b. KIND OF BUSINESS OR INDUSTRY retired | 11. BIRTHPLACE (City and State or Foreign Country) St. Louis Mo | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
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| 13a. FATHER'S NAME Michael Murphy | 13b. MOTHER'S MAIDEN NAME Emily Ryan | 14. NAME OF HUSBAND OR WIFE |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | 16. SOCIAL SECURITY NO. 489-039464 | 17. INFORMANT'S SIGNATURE OR NAME Mr. McCutchen 4567 Ave | ADDRESS |
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| 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. | 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CORONARY HEART DISEASE | | INTERVAL BETWEEN ONSET AND DEATH 30 MINUTES |
| | 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. _____ | | |

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| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION 420.1 | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
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| 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) |
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| 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? |
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22. I hereby certify that I attended the deceased from **Oct 28, 1955**, to **Nov 6, 1955**, that I last saw the deceased alive on **Nov 6, 1955**, and that death occurred at **1:10** am., from the causes and on the date stated above.

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| 23a. SIGNATURE (Degree or title) Vincent F Founsend MD | 23b. ADDRESS 3101^a Sutton Ave Maplewood | 23c. DATE SIGNED 7th 11-7-55 |
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|---|-------------------------------|---|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) | 24b. DATE Nov. 9, 1955 | 24c. NAME OF CEMETERY OR CREMATORY Calvary | 24d. LOCATION (City, town, or county) (State) St. Louis Mo. |
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| DATE REC'D BY LOCAL REG. NOV 8 1955 | REGISTRAR'S SIGNATURE Carl Smith M.D. | FUNERAL DIRECTOR'S SIGNATURE A. Howard | ADDRESS 1619 So. Grand |
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(Licensed Embalmer's Statement on Reverse Side)

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.....
Signature of Student Embalmer

Signed.....
J. Wm. Dunkley

Licensed Embalmer No. *365*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.