Health,
& Welfare
Public
Service

S. 300
1-56

FILED MAY 6 - 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

15077
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 3697

1. PLACE OF DEATH
a. COUNTY St. Louis, Mo.
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO. Inside Limits Yes ☐ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL Length of stay in 1b 3 days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY Franklin.
c. CITY OR TOWN St Clair Mo Inside Limits Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location) — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First ROSCOE Middle CONKLIN Last MURPHY

4. DATE OF DEATH Month APRIL Day 17 Year 1957

5. SEX M
6. COLOR OR RACE White
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH May 2, 1882
9. AGE (In years last birthday) 74 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) City Clerk
10b. KIND OF BUSINESS OR INDUSTRY St.Clair,Mo.
11. BIRTHPLACE (City and state or country) St.Clair,Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME F.A.Murphy
14. MOTHER'S MAIDEN NAME Virginia Hurt
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) none (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 488-12-8653
17. INFORMANT Nelle Murphy Address St.Clair,Missouri

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) INFARCT OF BOWEL — INTERVAL BETWEEN ONSET AND DEATH 4 DAYS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE — SEV YRS.
DUE TO (c) 420.0
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from APRIL 14, 1957 to APRIL 17, 1957 and last saw her/him alive on APRIL 17,1957
Death occurred at 8:45 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE [signature] (Degree or title) M. D.
22b. ADDRESS BARNES HOSPITAL
22c. DATE SIGNED 4/17/57

23a. BURIAL, CREMATION, REMOVAL (Specify) removal
23b. DATE 4-17-57
23c. NAME OF CEMETERY OR CREMATORY Odd Fellows Cemetery
23d. LOCATION (City, town, or county) (State) St.Clair,Missouri

24. FUNERAL DIRECTOR Sherwood Kitchell ADDRESS St.Clair,Missouri
25. DATE RECD. BY LOCAL REG. APR 17 '57
26. REGISTRAR'S SIGNATURE [signature] M.D.

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was emba

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed. Sherwood W. Kitchell.....

Licensed Embalmer No. 38.7

P. O. Address. St. Clair,

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Fa
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.