

Health, Welfare, Public Service
 300
 1-56
 All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.
 Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

58-012619

STATE FILE NUMBER

FILED MAR 31 1958

Registration District No. 317 Primary Registration District No. 544 Registrar's No. 831

| | | | | | | | | | |
|--|----------------------------------|---|--|--|---|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>St Louis</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St Louis</u> | | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kirkwood</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | c. CITY OR TOWN <u>Kirkwood</u> <u>4703</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>450 Meyer</u> | | | Length of stay in 1b <u>5 yrs</u> | | d. STREET ADDRESS <u>430 MEYER</u> | | Reside on a Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Patrick Henry Meyer MURPHY</u> | | | | 4. DATE OF DEATH Month Day Year <u>3-21-1958</u> | | | | | |
| 5. SEX <u>Male</u> <u>0</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>3-14-1869</u> | | 9. AGE (In years last birthday) <u>89</u> | IF UNDER 1 YEAR Months <u>0</u> Days <u>7</u> Hours <u>0</u> Min. <u>0</u> | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>self employed</u> | | 11. BIRTHPLACE (City and state or country) <u>Kirkwood Mo. 0</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | |
| 13. FATHER'S NAME <u>John Murphy</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Honora Field</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>499-28-1124A</u> | | 17. INFORMANT <u>Helen Louise Murphy 430 Meyer Kirkwood, Mo.</u> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | DUE TO (b) <u>Smoking</u> | | DUE TO (c) <u>4200</u> | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n) | | | | | | | | | |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m. | | | | | | | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 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 <u>2-2-53</u> , to <u>3-21-58</u> and last saw her ^{her} him _{him} alive on <u>3-21-58</u> Death occurred at <u>4:30P</u> m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | | | | | |
| 22a. SIGNATURE <u>Royal E. Neher, M.D.</u> (Degree or title) | | | | 22b. ADDRESS <u>Kirkwood, Mo.</u> | | | 22c. DATE SIGNED <u>3-22-58</u> | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City, town, or county) (State) | | | |
| <u>Buried</u> | | <u>3-24-1958</u> | | <u>St Joseph-Neier, Mo.</u> | | <u>Neier Mo.</u> | | | |
| 24. FUNERAL DIRECTOR LOUIS H. BOPP, INC. | | | | 25. DATE RECD. BY LOCAL REG. <u>3-23-58</u> | | 26. REGISTRAR'S SIGNATURE <u>Herbert P. Donke M.D.</u> | | | |
| <u>Kirkwood, Mo</u> | | | | (Licensed Embalmer's Statement on Reverse Side) | | | | | |

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 embalmed by me, or by, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Francis J. Mayland*

Licensed Embalmer No..... 48

P. O. Address *Hickory*

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