

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011232

STATE FILE NUMBER

2610

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

APR 6 1959

1. PLACE OF DEATH
a. COUNTY St Louis

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY St. Louis

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St Louis Inside Limits Yes No

c. CITY OR TOWN Ladue Inside Limits Yes No 4431

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St Lukes Length of stay in 1b _____

d. STREET ADDRESS (If outside, give location) 9 Oakleigh Lane Reside on Farm Yes No

3. NAME OF DECEASED First Middle Last
MARION - KERR - MURPHY

4. DATE OF DEATH Month Day Year
March 12, 1959

5. SEX female

6. COLOR OR RACE white

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH May 17, 1897

9. AGE (In years last birthday) 61 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) at home

10b. KIND OF BUSINESS OR INDUSTRY none

11. BIRTHPLACE (City and state or country) New York, New York

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Kerrner Kerr

13b. MOTHER'S MAIDEN NAME Unknown

14. NAME OF HUSBAND OR WIFE Russell W. Murphy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year and dates of service) none

16. SOCIAL SECURITY NO. none

17. INFORMANT Address William Murphy 9 Oakleigh Lane, Ladue Mo.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) chronic myocarditis

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) auricular fibrillation

DUE TO (c) 433,1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

INTERVAL BETWEEN ONSET AND DEATH 10 yrs
2 mo.

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. Month, Day, Year p.m.

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 Oct 10, 1930 to Mar. 12, 1959 and last saw her alive on March 12, 1959
Death occurred at 2:30 pm on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Charles Beebe M.D.

22b. ADDRESS 3720 Washington

22c. DATE SIGNED 3-13-59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE March 14, 1959

23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery

23d. LOCATION (City, town, or county) (State) St. Louis Missouri.

24. FUNERAL DIRECTOR ADDRESS C.R. Lupton and Sons 7233 Delmar Blv'd.

25. DATE RECD. BY LOCAL REG. MAR 14 '59

26. REGISTRAR'S SIGNATURE Walter Smith M.D.

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

300

-57

23 1 0

(H.T.)

1900-10-5 100 P. M.
Murphy
(City Vise)

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 *Arnold W. Schoene*

Licensed Embalmer No. *3864*

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.