

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-019469
STATE FILE NUMBER
Registrar 2 1918

Registration District No. _____ Primary Registration District No. _____

FILED JUN 4 1959

1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY _____	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips		d. STREET ADDRESS (If outside, give location) 4146 West. Belle	
Length of stay in lb _____		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle _____ Last Murphy			4. DATE OF DEATH Month 5 Day 18 Year 59
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 16, 1878
9. AGE (In years last birthday) 80		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) Retired		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and state or country) Mississippi
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME James Murphy	
13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE _____	
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. _____	17. INFORMANT Mrs. Bryant Address 5720 Julian
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO (b) Atherosclerosis DUE TO (c) 332x PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Chronic Pyelonephritis			INTERVAL BETWEEN ONSET AND DEATH 48 hrs.
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		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.)		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 5-10-59 to 5-18-59 and last saw ^{her} him alive on 5-18-59 Death occurred at 3:10 P m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE J. Inase (Degree or title) _____		22b. ADDRESS 2601 Whittier Street	
22c. DATE SIGNED 5-20-59		23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	
23b. DATE 5-21-59		23c. NAME OF CEMETERY OR CREMATORY Father Dickson Cemetery St. Louis County, Mo.	
23d. LOCATION (City, town, or county) (State) _____		24. FUNERAL DIRECTOR Metropolitan Funeral System, INC. ADDRESS 3010 Enright	
25. DATE RECD. BY LOCAL REG. MAY 20 1959		26. REGISTRAR'S SIGNATURE Loed Smith, M.D.	

Secretary, coroner, etc., must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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

John K Cunningham

Licensed Embalmer No. *4476*

P. O. Address *2475 Marene*

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.