

pt. Health,  
& Welfare  
S. Public  
Health Service

S. 300  
v. 1-57

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-027601

STATE FILE NUMBER

FILED VS AUG 3 1959

Registration District No. 317 Primary Registration District No. 578 Registrar's No. 1907

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Ill.</b> b. COUNTY <b>Wayne</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Webster Groves</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Wayne City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>120 Jersey</b>		Length of stay in lb <b>4 days</b>	d. STREET ADDRESS (If outside, give location) <b>8126 R</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>WILLIAM</b> Last <b>MURPHY</b>			4. DATE OF DEATH Month <b>July</b> Day <b>16</b> Year <b>1959</b>		
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 20, 1890</b>	9. AGE (In years last birthday) <b>69</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	11. BIRTHPLACE (City and state or country) <b>Princeton, Ind. / USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>William P. Murphy</b>		13b. MOTHER'S MAIDEN NAME <b>Alice Seabrooks</b>		14. NAME OF HUSBAND OR WIFE <b>Cecil W. Murphy</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, never or unknown) (If yes, give war or dates of service) <b>Yes W. W. I</b>		16. SOCIAL SECURITY NO. <b>339-16-5616</b>	17. INFORMANT Address <b>Mrs. H. L. Henry, 120 Jersey</b>		
18. CAUSE OF DEATH (Enter one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Unknown Natural Cause</b>					INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____					
DUE TO (c) _____					
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 <input type="checkbox"/> NO <input checked="" 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.) <b>7954</b>		
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____			20d. INJURY OCCURRED WHILE AT <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 _____, to _____ and last saw her/him alive on _____ Death occurred at <b>2 A</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Disease or title) <b>John C. Murphy MD/Asst. Health Commissioner</b>			22b. ADDRESS <b>801 S. Brentwood Clayton, Mo.</b>		22c. DATE SIGNED
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>7-18-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Old Hillsboro</b>		23d. LOCATION (City, town, or county) (State) <b>Hillsboro, Mo.</b>	
24. FUNERAL DIRECTOR ADDRESS <b>Parker-Aldrich, Webster Groves</b>			25. DATE RECD. BY LOCAL REG. <b>7-17-59</b>		26. REGISTRAR'S SIGNATURE <b>John C. Murphy MD/Asst.</b>

6561 8 AUG 1959

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 *Leslie Holch* .....

Licensed Embalmer No. *4395* .....  
P. O. Address *Water Grove* .....

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.