ISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

RTMENT OF PUBLIC HEALTH AND WELFARE

-61-042238
STATE FILE NUMBER

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11258

FILED DEC 12 1961

DATE AMENDED

INSTEAD OF

DOCUMENT

SHOULD READ

ITEM NO.

BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis
Length of stay in 1b
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): St. John's Hospital
Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo.
b. COUNTY
c. CITY OR TOWN: St. Louis
Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 6337 Marquette Ave.
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First LEONA Middle MAXINE Last MURPHY

4. DATE OF DEATH: Month Dec. Day 2 Year 1961

5. SEX: Female

6. COLOR OR RACE: White

7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: 3-22-1909

9. AGE (last birthday): 52

IF UNDER 1 YEAR: Months Days
IF UNDER 24 HR: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (City and state or country): Chicago, Ill.

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

13a. FATHER'S NAME: John Kowalskey

13b. MOTHER'S MAIDEN NAME: Mary Rose Rypel

14. NAME OF HUSBAND OR WIFE: William N. Murphy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None

17. INFORMANT: William N. Murphy
Address: 6337 Marquette Ave.

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): Cerebro Vascular Accident
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 331X
INTERVAL BETWEEN ONSET AND DEATH

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

PART III. If deceased was female was there a pregnancy in last 90 days.
☐ Yes ☒ No ☐ Unknown

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 ____ to ____ and last saw her/him alive on ____
Death occurred at 2:35 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Paul J. Simon (Degree or Title) Deputy Coroner

22b. ADDRESS: 1300 Clark

22c. DATE SIGNED: 12/4/61

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE: Dec. 6, 1961

23c. NAME OF CEMETERY OR CREMATORY: Resurrection Cemetery

23d. LOCATION (City, town, or county) (State): St. Louis Co. Mo.

24. FUNERAL DIRECTOR: Kriegshauser
ADDRESS: 4228 S. Kingshighway Blvd.

25. DATE RECD. BY LOCAL REG.: DEC 4 1961

26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

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 William B White

Licensed Embalmer No. 4291

P. O. Address_____

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.