

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

18732

1. PLACE OF DEATH

County.....
 Township.....
 City St. Louis (No. City Itap.)

Registration District No. 791
 Primary Registration District No. 1003

File No.....
 Registered No. 4031 St. _____ Ward)

2. FULL NAME Edward W. MURPHY

(a) Residence. No. 2509 Cass Ave. St. 21 Ward.....
 (Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 11-25-1919

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ____ hrs. or ____ min.
7 | 5 | 4

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work School Boy
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) St. Louis
 (STATE OR COUNTRY) mo

10. NAME OF FATHER Thomas Murphy

11. BIRTHPLACE OF FATHER (CITY OR TOWN) St. Louis
 (STATE OR COUNTRY) mo.

12. MAIDEN NAME OF MOTHER Loretta Doerr

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) St. Louis
 (STATE OR COUNTRY) mo.

14. INFORMANT Thomas Murphy
 (Address) 2509 Cass.

15. FILED 30 1927 May 6 Stancliff
 REGISTER

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-29 1927

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ 10:15 A. m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Shock & Injuries to L. Kidney, Spleen & too being struck over by Automobile (duration) _____ yrs. _____ mo. _____ da.

CONTRIBUTORY (SECONDARY) Accident (duration) _____ yrs. _____ mo. _____ da.

18. WHERE DISEASE CONTRIBUTED TO DEATH (IF NOT AT PLACE OF DEATH) _____

19. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____ WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS (Signed) R. J. [Signature], M. D.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Frieden's Cem DATE OF BURIAL May 2 1927

20. UNDERTAKER A. Kron & Co ADDRESS 2707 North Island

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

