WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

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

DEC'D APR 12 1939

9041
Do not use this space.

791

1. PLACE OF DEATH
(a) County 2 Registration District No. 1003
(b) Township 1 Primary Registration District No. Registered No. 2806
(c) or City St. Louis, Mo. (d) Street No. 3604a Clay Ave., St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 610 Edward Murphy,
(a) Residence, No. 3604a Clay Ave., St. 10
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct.30th,1886

7. AGE: YEARS 52 | MONTHS 4 | DAYS 24 | If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Linotype
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis, Mo. 0

FATHER
13. NAME William Murphy, 1
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois 0

MOTHER
15. MAIDEN NAME Margaret Hamilton,
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis, Mo.

17. INFORMANT (ADDRESS) Mrs. Anna Murphy, 3604a Clay Ave.,

18. BURIAL, CREMATION, OR REMOVAL
PLACE Memorial Park DATE Mar. 27th 39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Henry Leidner Und. Co. 1417 N. Market Street.

20. FILED MAR 25 1939 J. F. Bredeck Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 24, 1939

22. I HEREBY CERTIFY, That I attended deceased from June, 1937, 19.... to Mar. 24, 1939, 19....
I last saw him alive on March 21, 1939, 19.... Death is said to have occurred on the date stated above, at 3 A.M.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Chronic Myocarditis	June 1937
Other contributory causes of importance:	
Chronic interstitial Nephritis,	June 1937

Name of operation -- Date of
What test confirmed diagnosis? Urinalysis Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury ....., 19....
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify
(Signed) [signature], M. D.
(Address) 320 Metropolitan Bldg.

(Licensed Embalmer's Statement on Reverse Side)

Dr. O. E. Ramie

Lf 5101

Metropolitan Bldg

1-3 -6-8

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.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed Homer L. Ponder

Licensed Embalmer No. 3367

P. O. Address 2223 St. Louis Av

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 this body is not embalmed, above space should be left blank.