

Registration District No. **784** Primary Registration District No. **20**

1. PLACE OF DEATH:

(a) County **St. Louis,**
(b) City or town **Manchester**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Manchester Nursing Home** **3**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **2 years** (Specify whether years, months or days)
In this community **2 years**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **St. Louis**
(c) City or town **Manchester**
(If outside city or town limits, write "RURAL")
(d) Street No. **Manchester Nursing Home**
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct** day **-4-Oct 1** ?
year **1940** hour **d k** minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h_____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Coronary occlusion

Due to _____

Due to **g4hr**

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? **no** (Specify type of place) _____ (e) Means of injury _____

23. Signature **John S. Lammie** (M. D. or other) **10/1/40**
Address **Coroner of St. Louis Co.** Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

3. (a) PRINT FULL NAME **Pierce Murphy,**

3. (b) If veteran, name war **no** 3. (c) Social Security No. **no**

4. Sex **male** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **single**

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **December 6, 1867**
(Month) (Day) (Year)

8. AGE: Years **72** Months **9** Days **25** If less than one day hr. _____ min. _____

9. Birthplace **St. Louis Co., Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Quarry worker**

11. Industry or business _____

12. Name **Martin Murphy**

13. Birthplace **Ireland**
(City, town, or county) (State or foreign country)

14. Maiden name **Mary Gavin**

15. Birthplace **Ireland**
(City, town, or county) (State or foreign country)

16. (a) Informant **Kate Murphy**

(b) Address **2625 Oakview Ter.**

17. (a) **Burial** (b) Date thereof **10-5-1940**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. Peters Cem.**

18. (a) Signature of funeral director **Jay B. Smith**

(b) Address **7456 Manchester**

19. (a) **OCT - 5 1940** (b) **[Signature]**
(Date received local registrar) (Registrar's signature)

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..... *J. R. Burgess*.....

Licensed Embalmer No. *4029*.....

P. O. Address *Maplewood*.....

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, fact should be so stated above.