

FILED APR 8 1944

Registration District No. 317

Primary Registration District No. 6076

Registrar's No. 792

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Wellston
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
1342 Kingsland Avenue
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town Wellston
(If outside city or town limits, write "RURAL")

(d) Street No. 1342 Kingsland Avenue
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME CORA B. MURPHY

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife William Murphy 6. (c) Age of husband or wife if alive 68 years

7. Birth date of deceased September 20, 1879
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>64</u>	<u>6</u>	<u>10</u>	hr. _____ min. _____

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

10. Usual occupation At Home

11. Industry or business _____

MOTHER FATHER { 12. Name George T. Lewis

13. Birthplace Unknown Iowa
(City, town, or county) (State or foreign country)

14. Maiden name Mary Philibert

15. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant William Murphy

(b) Address 1342 Kingsland Avenue

17. (a) Burial (b) Date thereof April 1, 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cemetery

18. (a) Signature of funeral director Shepard Funeral Home

(b) Address 1187 Hamilton Avenue.

19. (a) APR 3-1944 (b) E. J. McLawrence, M.D.
(Date received local health officer) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 30, 1944
year 2 hour 30 minute P M.

21. I hereby certify that I attended the deceased from Sept 5 to Mar 30 1944
that I last saw h. alive on Mar 29 1944
and that death occurred on the date and hour stated above.

Immediate cause of death
Cerebral Hemorrhage
Second Hemorrhage
Chronic Myocarditis

Due to _____

Due to _____

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

Major findings: Paralysis rt side

Of operations _____

Of autopsy Q3d

Duration
4 1/2 yrs

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

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? _____ (Specify type of place) (e) Means of injury _____

23. Signature E. J. McLawrence (M. D. or other) _____
Address 427 Mississippi Blf State signed 3-31-44

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

96
0
0

Free for use
Suburban Home
430 - 600

APR 18 1944

18 19

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 John Gonski
Licensed Embalmer No. 3398

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 this body is not embalmed, fact should be so stated above.

3398 3398