

Registration District No. **1318**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County _____
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Firmin Desloge Hospital
(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

3. (a) PRINT FULL NAME **Emma S. Murphy**

3. (b) If veteran, name war _____ 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 **John L. Murphy** 6. (c) Age of husband or wife if alive **65** years

7. Birth date of deceased **May 1 1877**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	67	3	21	hr. min.

9. Birthplace **Trenton Illinois**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business _____

MOTHER FATHER

12. Name **John Haas**

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

14. Maiden name **Unknown**

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

16. (a) Informant **Raymond A. Murphy**

(b) Address **725 Marion St.**

17. (a) **Burial** (b) Date thereof **8-23-44**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Lubbebring, Mo.**

18. (a) Signature of funeral director **Albert H. Hoppe**

(b) Address **224700 Washington Blvd.**

19. (a) **AUG 22 1944** (b) **J. F. Bredeick**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Franklin**
(c) City or town **Grubbbville**
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug.** day **22**
year **1944** hour **6:30** minute **A.** M.

21. I hereby certify that I attended the deceased from **June 1943**
to **Aug 21 1944**
that I last saw her alive on **Aug 21 1944**
and that death occurred on the date and hour stated above.

Immediate cause of death
cardiac failure
Due to **cardiac hypertrophy** 1-yr
Due to **hypertension** 2-3-4ys

Other conditions (Include pregnancy within 3 months of death)
95

Major findings:
Of operations _____
Of autopsy _____

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

23. Signature **Fred Kramer** (M. D. or other) **M.D.**
Address **634 N Brand** Date signed **8-22-44**

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

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 Agnoski
Licensed/Embalmer No. 2398
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.