

FILED SEP 30 1944

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 7980

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution:  
4530a Enright 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 St. Louis  
(If outside city or town limits, write "RURAL")

(d) Street No. 4530a Enright Avenue.  
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Oma Murphy Whiteside.

3. (b) If Veteran, name war None

3. (c) Social Security No. 500-16-4779

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Divorced

6. (b) Name of husband or wife Edward J. Murphy.

6. (c) Age of husband or wife if alive 40 years

7. Birth date of deceased January 7, 1899.  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>45</u>	<u>8</u>	<u>8</u>	_____ hr. _____ min.

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

10. Usual occupation Shoe worker.

11. Industry or business \_\_\_\_\_

12. Name William Decker.

13. Birthplace Osage County, Missouri.  
(City, town, or county) (State or foreign country)

14. Maiden name Cornelia Creider.

15. Birthplace Osage County, Missouri.  
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. Jefferson Decker.

(b) Address 4530a Enright Avenue.

17. (a) Burial (b) Date thereof 9/18/1944.  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Lebanon Cemetery.

18. (a) Signature of funeral director Geo. L. Pleitsch, Inc.

(b) Address 5966-68 Easton Avenue.

19. (a) SEP 18 1944 (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September Day 15th.  
year 1944 hour 12 minute 15 A.M.

21. I hereby certify that I attended the deceased from 2-10-44 to Sept 15 1944  
that I last saw her alive on Sept 15 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of female pelvic organs

Due to \_\_\_\_\_

Due to Primary site in uterus

Other conditions in uterus  
(Include pregnancy within 3 months of death)

Major findings: H&E

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

Duration

8 mo

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? No (Specify type of place)

(e) Means of injury \_\_\_\_\_

23. Signature A F Herzer (M. D.) \_\_\_\_\_  
W. A. Kingsbury Date signed 9-16-44

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

MOTHER FATHER

Dr. A.F.Lerner.  
1520 North Kingshighway.  
Hours 1 to 3 P.M.  
Telephone Forest 5340

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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:

*Ben Hoffman*

Licensed Embalmer No.

*4366*

P. O. Address

*Home, Mo*

**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.