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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

25974

FILED AUG 24 1945  
318

State File No. \_\_\_\_\_

Registrar's No. 7052

Registration District No. \_\_\_\_\_ Primary Registration District No. 1003

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: Gruesch Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 6 hours  
(Specify whether  
In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME Lucille Doyle Murphy  
3. (b) If veteran, name war None  
3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race White  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Walter Murphy  
6. (c) Age of husband or wife if alive 52  
7. Birth date of deceased 3-12-1893  
(Month) (Day)

8. AGE: Years 47 ~~48~~ Months 5 ~~4~~ Days 7 ~~2~~  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Columbus Texas  
(City, town, or county) (State or foreign country)

10. Usual occupation Clerk

11. Industry or business Furniture Business

12. Name Michael J. Doyle

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

14. Maiden name Ruth Lilly

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

16. (a) Informant Walter Murphy

(b) Address Cheyenne Mo

17. (a) Reburial (b) Date thereof 8-11-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cheyenne Mo

18. (a) Signature of funeral director Louis H. Bopp

(b) Address Subwood Mo

19. (a) AUG 11 1945 (b) J. F. Bruback  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Leramine  
(c) City or town Cheyenne Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. Ranch (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 10 year 1945 hour 6 minute 30 a.m.

21. I hereby certify that I attended the deceased from Aug 9 to Aug 10 1945  
that I last saw her alive on Aug 10 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Diabetic Coma Duration \_\_\_\_\_

Due to Diabetes  
sup + + + + -

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

Other conditions Uterine Fibroid  
(Includes pregnancy within 3 months of death)

Major findings: No operation

Of operations \_\_\_\_\_  
Of autopsy 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 John H. Amstutz (M. D. or other) M.D.

Address 224 N. Webster St. St. Louis Date signed Aug 11/45

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

66  
17  
9

7052  
7052

JUL 28 1945

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 Felix Durand

Licensed Embalmer No. 3034

P. O. Address. Lukenord 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.