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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED SEP 4 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29352

State File No.

Registration District No. **318** Primary Registration District No. **100E** Registrar's No. **8127**

1. PLACE OF DEATH:
(a) County **St. Louis, Missouri**
(b) City or town **St. Louis, Missouri**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution
963 Goodfellow Blvd.
(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. **963 Goodfellow**
5 (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Bertha Elizabeth 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 **Single**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **November 28, 1871**
(Month) (Day) (Year)
8. AGE: Years **75** Months **8** Days **27** If less than one day _____ hr. _____ min.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **August** day **25th** year **1947** hour **4** minute **30 P. M.**
21. I hereby certify that I attended the deceased from **January 15th 1947** to **August 25th 1947**
that I last saw her alive on **August 22nd 1947** and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic myocarditis** Duration **1 year**
Due to **Arterio-sclerosis** **5 years**
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy _____
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) **none**
(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 _____
Signature **J. F. Gallagher** (M. D. or other) _____
Address **3903 Olive** Date signed **8/26/47**

MOTHER FATHER
9. Birthplace **St. Louis, Missouri**
(City, town, or county) (State or foreign country)
10. Usual occupation **None**
11. Industry or business _____
12. Name **James M. Murphy**
13. Birthplace **Ireland**
(City, town, or county) (State or foreign country)
14. Maiden name **Mary Kilroy**
15. Birthplace **Louisiana**
(City, town, or county) (State or foreign country)
16. (a) Informant **B. Mary Murphy**
(b) Address **963 Goodfellow**
17. (a) **Burial** (b) Date thereof **8-28-47**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Mt. Olive Cemetery**
Southern Funeral Home
18. (a) Signature of funeral director _____
(b) **AUG 27 1947**
19. (a) _____ (b) **J. F. Gallagher**
(Date received local registrar) (Registrar's signature)

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

SED

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 Albert G. Hoppe
Licensed Embalmer No. 2971
P. O. Address St. Louis, 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.