No. 2
1/47
17-39
X

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 6806

FILED MAR 4 1948

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 1707

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: Homer G Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 14 days (Specify whether
In this community 10 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 000
(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No. 714 N Leonard 9
21 (If rural, give location)
(e) Citizen of foreign country? (Yes or No) 0
If yes, name country

3. (a) PRINT FULL NAME Columbus Murphy
3. (b) If veteran, name war No
3. (c) Social Security No.
4. Sex Male 2
5. Color or race Col
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Minnie Moore Murphy
6. (c) Age of husband or wife if alive 43 years
7. Birth date of deceased Nov (Month) 11 (Day) 1901 (Year)

8. AGE:

Years	Months	Days	If less than one day
46	9	5	hr. min.

9. Birthplace (City, town, or county) Miss (State or foreign country)
10. Usual occupation unemployed
11. Industry or business
FATHER
12. Name Unknown Murphy
13. Birthplace (City, town, or county) Miss (State or foreign country)
MOTHER
14. Maiden name Lula Agnew
15. Birthplace (City, town, or county) Miss (State or foreign country)
16. (a) Informant Minnie Moore Murphy
(b) Address 714 N. Leonard
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 2/19/48 (Month) (Day) (Year)
(c) Place: burial or cremation Gum Town Miss
18. (a) Signature of funeral director [illegible]
(b) Address 3517 Cascade Ave
19. (a) FEB 9 1948 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 16
year 1948 hour 7 minute 25 p M.

21. I hereby certify that I attended the deceased from Feb. 2, 1948 to Feb. 16, 1948; that I last saw him alive on Feb. 16, 1948; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death HEART — Hypertrophy	Undet.
Due to	
Due to	
Other conditions Bronchial Pneumonia (Include pregnancy within 3 months of death)	Undet.

Major findings:
Of operations
Of autopsy Yes

PHYSICIAN
Underline the cause of 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? (Specify type of place)
While at work? (e) Means of injury 0

23. Signature Oscar L Daniels (M. D. or other)
Address 2601 N Whittier Date signed 2/17/48

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

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 Jesse E Hurd, Registered Apprentice No. 514 working under my personal supervision.

Signed [illegible]

Licensed Embalmer No. 1173

P. O. Address 3517 [illegible]

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

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

No. 2B
3-45
X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. March

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 1707

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

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County
(c) City or town
(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

3. (a) PRINT FULL NAME Columbus Murphy
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex M
5. Color or race B
6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive
7. Birth date of deceased May 11 1900 (Month) (Day) (Year)
8. AGE: Years 46 Months 9 Days If less than one day hr. min.
9. Birthplace (City, town, or county) Miss (State or foreign country)
10. Usual occupation Unemployed
11. Industry or business
MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director R.M.C. Green
(b) Address 3517 Laclede Ave
19. (a) (Date received local registrar) (b) J. F. Bretsch (Registrar's signature)
MAR 5 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February year 1948 hour minute M.
21. I hereby certify that I attended the deceased from , 19 to , 19 ; that I last saw him alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death — Duration

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

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? (Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

6806

1985-[illegible]