

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **25686**
Registrar's No. **6627**

FILED JUL 22 1952

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1003

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE _____ b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		J	
d. FULL NAME OF HOSPITAL OR INSTITUTION 2631 Thomas St.				d. STREET ADDRESS (If rural, give location) 2631 Thomas Strd.			
3. NAME OF DECEASED (Type or Print) Sarah		a. (First) _____		b. (Middle) _____		c. (Last) Curry	
4. DATE OF DEATH July 4, 1952		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed		8. DATE OF BIRTH 8-10-1885		9. AGE (In years last birthday) 66	
5. SEX Female		6. COLOR OR RACE Colored		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Mississippi	
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY none		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13a. FATHER'S NAME Peter Murphy		13b. MOTHER'S MAIDEN NAME Sarah Murphy		14. NAME OF HUSBAND OR WIFE Deceased			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Augusta Knight ADDRESS 2631 Thomas Strd.			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Myocarditis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>				INTERVAL BETWEEN ONSET AND DEATH Several days	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR _____ 4222			
22. I hereby certify that I attended the deceased from June 1st, 1952 to July 4th 1952 that I last saw the deceased alive on July 3rd, 1952 and that death occurred at 5A. m. from the causes and on the date stated above.							
23a. SIGNATURE Clara B. Kane (Degree or title) MD. 100				23b. ADDRESS 706 Walton		23c. DATE SIGNED 7-8-52	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 7-12-52		24c. NAME OF CEMETERY OR CREMATORY Washington Park		24d. LOCATION (City, town, or county) (State) St. Louis County Mo.	
DATE REC'D BY LOCAL REG. JUL 8 1952		REGISTRAR'S SIGNATURE J. Carl Smith MD		25. FUNERAL DIRECTOR'S SIGNATURE Ellis Funeral Home Inc. 2820 Stoddard ADDRESS _____			

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

mjb

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.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed Fulton E. Culkin

Licensed Embalmer No. 498

P. O. Address St Louis 13

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.