

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **24150**
Registrar's No. **5888**

DECEASED **AUG 2 - 1955**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Little Sisters		f. STREET ADDRESS (If rural, give location) 3400 S. Grand Blvd. 21690	

3. NAME OF DECEASED (Type or Print) a. (First) Patrick b. (Middle) c. (Last) Murphy			4. DATE OF DEATH (Month) (Day) (Year) July 6, 1955		
--	--	--	--	--	--

5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single		8. DATE OF BIRTH ---- 1881		9. AGE (In years last birthday) ab. 74		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
--------------------	--	-------------------------------	--	---	--	--------------------------------------	--	---	--	--------------------------------	--	--------------------------------	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer - Day			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (City and State or Foreign Country) Ireland #			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
---	--	--	-----------------------------------	--	--	--	--	--	---	--	--

13a. FATHER'S NAME Edward Murphy			13b. MOTHER'S MAIDEN NAME Mary Sheridan			14. NAME OF HUSBAND OR WIFE B		
--	--	--	---	--	--	---	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. ---		17. INFORMANT'S SIGNATURE OR NAME Sister Henry				ADDRESS 3400 S. Grand Blvd.	
--	--	---------------------------------------	--	--	--	--	--	---------------------------------------	--

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) Arteriosclerotic Heart Disease					INTERVAL BETWEEN ONSET AND DEATH years	
			ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Generalized arteriosclerosis						
			DUE TO (c)						
			II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
------------------------	--	----------------------------------	--	--	--	--	--	---	--

21a. ACCIDENT SUICIDE HOMICIDE (Specify) No		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) m.			21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 4200	
--	--	--	--	--	---	--

22. I hereby certify that I attended the deceased from **1953**, 19____, to **July 6, 1955**, that I last saw the deceased alive on **7/6/55**, and that death occurred at **7:15P** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Albert Reynolds MD			23b. ADDRESS 405 W. ... St. Louis			23c. DATE SIGNED 7/7/55		
---	--	--	---	--	--	-----------------------------------	--	--

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 7/11/55		24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis Mo	
--	--	-----------------------------	--	---	--	--	--

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE JUL 8 - 1955 Carl Smith MD		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS John H. Gabrah Sons 2630 Grayols Ave.	
--	--	--	--

(Licensed Embalmer's Statement on Reverse Side)

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

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.....
Signature of Student Embalmer

Signed *Robert F. Gebke*

Licensed Embalmer No... *414*

P. O. Address *2630 Gra*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.