

FILED SEP 11 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

30300

STATE FILE NUMBER

 Registration District No. 317 Primary Registration District No. 542 Registrar's No. 2109

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Ferguson</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Hilltop House</b>		Length of stay in lb <b>3 1/2 yrs.</b>	26 <sup>9</sup> STREET ADDRESS <b>5342 Greer Ave.</b> (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Murphy</b> Last <b>Phillips</b>			4. DATE OF DEATH Month <b>8</b> Day <b>22</b> Year <b>57</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 3, 1883</b>	9. AGE (In years last birthday) <b>74</b>	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) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (City and state or country) <b>Kilkenny, Ireland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>unknown</b>			14. MOTHER'S MAIDEN NAME <b>unknown</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT Address <b>Mr. Matt Phillips, 5342 Greer Ave.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral vascular accident</b>					INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					DUE TO (b) _____ DUE TO (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>331X</b>		
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION		COUNTY _____ STATE _____
21. I attended the deceased from <b>Feb 1 - 1955</b> to <b>Aug 22 - 1957</b> and last saw her <del>him</del> alive on <b>Aug 22 - 1957</b> . Death occurred at <b>10:50</b> a. m. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Type or print) <b>John G. M. Sweeney M.D.</b>			22b. ADDRESS <b>5014 Thekla Ave</b>		22c. DATE SIGNED <b>8/23/57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>	23b. DATE <b>8/26/57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>		23d. LOCATION (City, town, or county) <b>St. Louis</b> (State) <b>Mo.</b>	
24. FUNERAL DIRECTOR <b>Drehmann-Harral</b>		ADDRESS <b>1905 Union</b>		25. DATE RECD. BY LOCAL REG. <b>8-23-57</b>	26. REGISTRAR'S SIGNATURE <b>Robert H. D... M.D.</b>

(Licensed Embalmer's Statement on Reverse Side)

diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

 b, fare  
ce  
ice

Dr. John G. McSwiney  
5014 Thekla  
Ev. 5-4688

Hrs. Fri. 6:30-8:00 PM  
. Sat. 9:30-11:00 AM

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 *Albert R. Thompson* .....

Licensed Embalmer No. 4 .....

P. O. Address *H. J. ...*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.  
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.