

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS NOV 28 1960

-60-044623

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 590 Registrar's No. 3347

DED

1. PLACE OF DEATH a. COUNTY St. Louis			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY		
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN Rural Wellston		Length of stay in 1b 25 yrs. 8 mos.	c. CITY OR TOWN Peoria		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Vincent's Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 3001 Carver Ave.		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last MARGARET MURPHY (SISTER MARY OF ST. THOMAS)			4. DATE OF DEATH Month Day Year November 16, 1960		
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2-17-1882	9. AGE (last birthday) 78	IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NUN		10b. KIND OF BUSINESS OR INDUSTRY RELIGION	11. BIRTHPLACE (City and state or country) Ballynallis County Mayo, Ireland		12. CITIZEN OF WHAT COUNTRY Ireland
13a. FATHER'S NAME Robert Murphy		13b. MOTHER'S MAIDEN NAME Bridget Kane		14. NAME OF HUSBAND OR WIFE Never married	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Records of St. Vincent's Hospital	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer, metastatic, original site unknown					INTERVAL BETWEEN ONSET AND DEATH 4 months
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) Generalized Arteriosclerosis - Yrs. Chronic Schizophrenia - Yrs.			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)			
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year					
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 Jan. 1, 1948 to Nov. 16, 1960 and last saw her/him alive on November 16, 1960 Death occurred at 11:35 P. M. on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE S. R. BANEY, M.D. (Physician or title)			22b. ADDRESS 7301 St. Charles Rock Rd.		22c. DATE SIGNED 11-17-60
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE 11/18/1960	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis, Missouri
24. FUNERAL DIRECTOR Arthur J. Womely		ADDRESS 3840 Lindell Blvd.		25. DATE RECD. BY LOCAL REG. 11-17-60	26. REGISTRAR'S SIGNATURE John C. Murphy, M.D.

DOCUMENT

MEDICAL CERTIFICATION

AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Joan Hill

Licensed Embalmer No. 35

P. O. Address 3846

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