

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-024988

Registered District No. **318** Primary-Registration District No. **1003** Registrar's No. **6358** STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

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USE BLACK INK OR TYPEWRITER RIBBON

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

SHOULD READ

DOCUMENT MEDICAL CERTIFICATION BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MISSOURI</i> b. COUNTY <i>ST. LOUIS</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>ST. LOUIS</i>		Length of stay in 1b <i>5 DAYS</i>	c. CITY OR TOWN <i>ST. LOUIS</i> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>ST. ANTHONY HOSPITAL</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <i>320 EAST RIPA</i> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <i>KATHLEEN REGINA MURPHY</i>		4. DATE OF DEATH Month Day Year <i>JUNE 26 1962</i>	
5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <i>8/26/43</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) <i>18</i> IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.
11. BIRTHPLACE (City and state or country) <i>ST. LOUIS, MISSOURI</i>		12. CITIZEN OF WHAT COUNTRY <i>USA</i>	
13a. FATHER'S NAME <i>JAMES THOMAS MURPHY</i>		13b. MOTHER'S MAIDEN NAME <i>MARY MARGARET HANNON</i>	14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO.	17. INFORMANT <i>SISTER KATHLEEN</i> Address <i>320 EAST RIPA</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Ruptured cerebral aneurysm</i> Conditions, if any, which are not so above / cause (b) <i>330X</i> DUE TO (c) <i>Pulmonary edema</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>
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.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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 <i>June 1, 1962</i> , to <i>June 25, 1962</i> and last saw her alive on <i>June 25, 1962</i> Death occurred at <i>1:30 A.M. June 26</i> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>Shera F. Ortmeier MD</i>		22b. ADDRESS <i>2023 Telegraph Rd</i>	22c. DATE SIGNED <i>June 26, 1962</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>REMOVAL</i>	23b. DATE <i>JUNE 28, 1962</i>	23c. NAME OF CEMETERY OR CREMATORY <i>NOTRE DAME CONVENT Cem.</i>	23d. LOCATION (City, town, or county) (State) <i>ST. LOUIS Mo.</i>
24. FUNERAL DIRECTOR ADDRESS <i>James Kutis 2906 Gravois</i>		25. DATE RECD. BY LOCAL REG. <i>JUN 27 1962</i>	26. REGISTRAR'S SIGNATURE <i>Coal Smith MD</i>

Not OK from  
Mrs Rayless

**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 Eleana Poirnee

Licensed Embalmer No. 3403

P. O. Address 2906 grove

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.