

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-044669

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

1003

11876

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318**

Primary Registration District No. _____

Registrar's No. _____

FILED DEC 14 1962

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		Length of stay in 1b 60 Years		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY St. Louis		c. CITY OR TOWN Webster Groves		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS 583 Hollywood Place		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last CLINT KELLY MURPHY			4. DATE OF DEATH Month Day Year DECEMBER 9 1962			5. SEX Male		6. COLOR OR RACE White		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 1/14/1890		9. AGE (last birthday) 72		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Photographer (Retired)				10b. KIND OF BUSINESS OR INDUSTRY Post - Dispatch		11. BIRTHPLACE (City and state or country) Owensboro, Kentucky		12. CITIZEN OF WHAT COUNTRY U.S.A.									
13a. FATHER'S NAME Clint Griffith Murphy				13b. MOTHER'S MAIDEN NAME Laura Massy				14. NAME OF HUSBAND OR WIFE Agnes Murphy									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None						17. INFORMANT Address Mrs Agnes Murphy 583 Hollywood Place											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumococcal Meningitis DUE TO (b) Pneumonia DUE TO (c) 491x Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.												INTERVAL BETWEEN ONSET AND DEATH 24 hours 2 days					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)								PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown									
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.)													
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 1957 to 12/9/62 and last saw him alive on 12/9/62 . Death occurred at 8:20 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.																	
22a. SIGNATURE (Degree or title) Hugh R. Walters M.D.						22b. ADDRESS BARNES HOSPITAL		22c. DATE SIGNED 12/10/62									
23a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		23b. DATE 12/12/62		23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		23d. LOCATION (City, town, or county) St. Louis, Missouri		23e. (State)									
24. FUNERAL DIRECTOR ADDRESS Alexander & Sons 6175 Delmar Blvd				25. DATE RECD. BY LOCAL REG. DEC 11 1962		26. REGISTRAR'S SIGNATURE Boad Smith. M.D.											

STATE OF MISSISSIPPI

DEPARTMENT OF HEALTH

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 J. Allen Rainey Jr

Licensed Embalmer No. 4053

P. O. Address Dec 9-1962

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.