

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-013634

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **3325**

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

**FILED MAR 28 1963**

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST LOUIS,</b>		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> COUNTY		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>4847 CARTER AVE</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS <b>4847 CARTER AVE</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)			First <b>ANNA</b>			Middle			Last <b>MURPHY</b>			4. DATE OF DEATH Month Day Year <b>MARCH 21, 1963</b>					
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>7-13-1882</b>		9. AGE (last birthday) <b>80</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CLERK</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (City and state or country) <b>ST LOUIS MISSOURI</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>							
13a. FATHER'S NAME <b>JOHN MURPHY</b>						13b. MOTHER'S MAIDEN NAME <b>MARGARET GANNON</b>						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) <b>NO</b>						16. SOCIAL SECURITY NO.						17. INFORMANT Address <b>FRANK MURPHY 4847 CARTER AVE</b>					
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> DUE TO (b) <b>Generalized arteriosclerosis</b> DUE TO (c) <b>4201</b>												INTERVAL BETWEEN ONSET AND DEATH <b>None</b>					
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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT. SUICIDE. HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 <b>Feb 11, 1963</b> to <b>March 24, 1963</b> and last saw her alive on <b>Mar 27, 1963</b> Death occurred at <b>7am</b> on the date stated above, and to the best of my knowledge, from the causes stated.																	
22a. SIGNATURE <i>John F. Stroot</i> (Degree or title)						22b. ADDRESS <b>4703 Carter Dr. St. Louis</b>						22c. DATE SIGNED <b>3-21-63</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>3/23/63</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CALVARY CEMETERY</b>				23d. LOCATION (City, town, or county) <b>ST LOUIS MISSOURI</b>									
24. FUNERAL DIRECTOR <b>STROOT - CARROLL 4600 NATURAL BRIDGE</b>						ADDRESS		25. DATE RECD. BY LOCAL REG. <b>MAR 22 1963</b>		26. REGISTRAR'S SIGNATURE <i>Loed Smith, M.D.</i>							

USE BLACK INK OR TYPEWRITER RIBBON

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*Dr. J. J. Carter*  
*Maximus & Carter*

**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 *M W Rueter*

Licensed Embalmer No. 4865

P. O. Address St Louis MO

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.