

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-042373

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3215

FILED OCT 30 1963

DO NOT WRITE ON THIS STUB

AMENDED

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) Ballwin		c. CITY OR TOWN Richmond Heights	
Length of stay in 1b 2 years		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Maria de Villa Retirement Center		d. STREET ADDRESS (If outside, give location) 1344 McCutcheon	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JAMES K. MURPHEY, Sr.			4. DATE OF DEATH Month October Day 18 Year 1963
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6/22/75
9. AGE (last birthday) 88		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) Retired		10b. KIND OF BUSINESS OR INDUSTRY Oil Company	11. BIRTHPLACE (City and state or country) Hickman, Ky.
12. CITIZEN OF WHAT COUNTRY USA		13. NAME OF HUSBAND OR WIFE Allie Murphey, Dec'd.	
13a. FATHER'S NAME James Murphey		13b. MOTHER'S MAIDEN NAME Betty Miles	
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. [REDACTED]	
17. INFORMANT Address Jas. K. Murphey, Jr. #8 Oak Bend Dr. Ladue, Mo.		17. INFORMANT Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cerebral thrombosis			INTERVAL BETWEEN ONSET AND DEATH 2 weeks
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) cerebral arteriosclerosis			2 yr.
DUE TO (c) _____			
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 11-15-61 to 10-18-63 and last saw him alive on 10-16-63 Death occurred at 12:30 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
21. SIGNATURE (Degree or title) <i>[Signature]</i>		22b. ADDRESS 950 Francis Place Clayton Mo	22c. DATE SIGNED 10-18-63
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10/21/63	23c. NAME OF CEMETERY OR CREMATORY Valhalla Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis County, Mo.
24. FUNERAL DIRECTOR Bopp Chapel, Kirkwood, Mo.	25. DATE RECD. BY LOCAL REG. 10-21-63	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

INVESTIGATION

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

Francis J. [Signature]

Licensed Embalmer No. 4512

P. O. Address Richwood, 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.