MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

22657

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

City St Louis (No. City Hospital ..... St. ..... Ward)

File No. .....

Registered No. 6309

2. FULL NAME John J Moloney

(a) Residence. No. 1410 N Grand St., 21 Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Divorced

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Marion Moloney

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Nov 29 1884

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
42	7	10	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Restuarant Owner
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN): St Louis
(STATE OR COUNTRY): Missouri

PARENTS

10. NAME OF FATHER: John Moloney
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Ireland
12. MAIDEN NAME OF MOTHER: Mary Hill
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Ireland

14. INFORMANT: Marion Moloney
(Address) 4447 Elmbank Ave

15. FILED 11 10 1927 Max C Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): July 9 1927

17. I HEREBY CERTIFY, That I attended deceased from 7-1, 1927, to 7-9, 1927 that I last saw h. ~~[illegible]~~ alive on 7-9, 1927 and that death occurred, on the date stated above, at 1 35 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Right Lobar Pneumonia

108

101a

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) John W. Hotz, M. D
, 19 (Address) City Hospital

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Calvary
DATE OF BURIAL: 7-11 1927

20. UNDERTAKER: Arthur J Dormelly
ADDRESS: 2039 Wash St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

City Hospital