APR 28 1930

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

Do not use this space.

8239

1. PLACE OF DEATH
County: Franklin
Township: Union
City: ..... (No. ....., ... St. ..... Ward)

Registration District No. 282
Primary Registration District No. 5401

File No. .....
Registered No. 12

2. FULL NAME: Paul Mooney

(a) Residence. No. ..... St., ... 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: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Feb 19-27

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
3	—	23	

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

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY): Mo

PARENTS

10. NAME OF FATHER: Elmore Mooney
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY): Ill
12. MAIDEN NAME OF MOTHER: Della Kitchen
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY): Mo

14. INFORMANT: Father
(Address): Pacific

15. FILED: 3/15, 1930 E W Landers
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): March 14 1930

17. I HEREBY CERTIFY, That I attended deceased from Feb ....., 1930, to Mar 2 10, 1930 that I last saw him alive on Mar 2 10, 1930 and that death occurred, on the date stated above, at 11 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bronchio Pneumonic
IIR
Lobar
(duration) ..... yrs. ..... mos. ..... ds.

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

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? —
DID AN OPERATION PRECEDE DEATH? No. DATE OF —
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? None
(Signed) W. L. Cone, M. D
, 19 (Address) April 3 - 1930.

*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: Oak Grove
DATE OF BURIAL: 3/15 1930

20. UNDERTAKER: E W Landers
ADDRESS: Campbell

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.