

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

Do not use this space.

37296

1. PLACE OF DEATH

County St. Louis, Mo.

Township Carrville

City Jefferson Barracks, Mo.

Registration District No. 1123

Primary Registration District No. 6248 B

U.S. Veterans Hospital, Jefferson Brks, Mo. (Ward)

File No.

Registered No. 395

2. FULL NAME

Daniel J. Moriarty.

(a) Residence No. 4512-A Delmar Blvd., St. Louis, Mo. Ward.

(Usual place of abode)

(If nonresident give city or town and State)

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male.

4. COLOR OR RACE

White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Married.

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

Mrs. Julia Moriarty.

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

Sept. 14, 1884

7. AGE

YEARS
46

MONTHS
2

DAYS
16

IF LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Plumber helper.

(b) General nature of industry, business, or establishment in which employed (or employer) Unavailable.

(c) Name of employer Unavailable.

9. BIRTHPLACE (CITY OR TOWN)

Unavailable.

(STATE OR COUNTRY)

Ireland.

10. NAME OF FATHER

Unavailable.

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

Unavailable.

(STATE OR COUNTRY)

Unavailable.

12. MAIDEN NAME OF MOTHER

Unavailable.

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

Unavailable.

(STATE OR COUNTRY)

Unavailable.

14.

INFORMANT C.H. Smith

(Address) U.S. Veterans Hospital, Jefferson Barracks, Mo.

15.

FILED Nov 2 19 37 L. C. Abrod REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 30, 19 30

17.

I HEREBY CERTIFY, That I attended deceased from November 10, 19 30, to November 30, 19 30 that I last saw him alive on November 30, 19 30 and that death occurred, on the date stated above, at 9:17 PM.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Tuberculosis, Pulmonary, chronic. Far advanced, active.

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED?

IF NOT AT PLACE OF DEATH: Unknown.

19. DID AN OPERATION PRECEDE DEATH? No. DATE OF _____

WHAT TEST CONFIRMED DIAGNOSIS? Physical, X-Ray & Laboratory findings.

(Signed) C.H. Smith Acting Medical Officer
19 Nov 30 (Address) In Charge.

*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

DATE OF BURIAL

National Cemetery 12/3 30

20. UNDERTAKER

ADDRESS

C. Hoffmeister & Co 7814 Broadway

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.

RECORDING INK—THIS IS A PERMANENT RECORD

