

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.

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

32732
 Do not use this space.

1. PLACE OF DEATH

(a) County.....
 (b) Township.....
 (c) City.....**St. Louis**
 (d) Street No. **3628 Cook avenue**
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. **3628 Cook avenue** St. **III**
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Fem.** 4. COLOR OR RACE **W.** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Widow**
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Thomas J. Molloy**
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Apr. 12, 1873**
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
64 **MM-5** **6**

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **housewife**
 9. Industry or business in which work was done, as saw mill, bank, etc. **--**
 10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **St. Louis, Mo.**

FATHER 13. NAME **Thomas Fox**
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Ireland**

MOTHER 15. MAIDEN NAME **Ann Farrell**
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **St. Louis**

17. INFORMANT **Thomas Molloy, 3628 Cook Ave**
 (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE **Calvary Cem.** DATE **9/21/37**

19. FUNERAL DIRECTOR (ADDRESS) **Cullinane Brothers**
1710 N. Grand Blvd.

20. FILE **SEP 20 1937** **J. Bredeck**
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Sept. 18, '37**
 22. I HEREBY CERTIFY, That I attended deceased from **Oct 1st**, 1936, to **Sept 18th**, 1937
 I last saw him alive on **Sept 18th**, 1937. Death is said to have occurred on the date stated above, at **8:40 p.m.**
 The principal cause of death and related causes of importance were as follows:

Date of onset **Oct 1-30**
Carcinoma of lumbar vertebrae
 Other contributory causes of importance: **532**

Name of operation..... Date of.....
 What test confirmed diagnosis? **X-Ray** Was there an autopsy? **No**

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide?..... Date of injury....., 19.....
 Where did injury occur?..... (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....
 Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? **Yes**
 If so, specify **Edwin L. Sheehan**, M. D.
 (Signed) **7. E. L. F. Smythe**
 (Address)

STATEMENT BY LICENSED EMBALMER

I, Fred Frick, Licensed Embalmer No. 3186

hereby certify that the body recorded on the reverse side of this certificate was embalmed by myself

L. E.

No. _____ or by _____, Registered Apprentice No. _____
working under my personal supervision.

Signed

Fred Frick

Licensed Embalmer No. 3186

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.)