

REC'D SEP 9 1938

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

29944
Do not use this space.

1. PLACE OF DEATH

(a) County St. Louis Registration District No. 284
 (b) Township _____ Primary Registration District No. 101 Registered No. 1393
 (c) City Clayton (d) Street No. 7540 Maryland Ave. St. _____
 (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 18 yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Rebecca S. Moloney 4570

(a) Residence, No. 7540 Maryland Ave. St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (writes the word) Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Frank T. Moloney
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept. 21/1876
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
61 10 29
 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) June 1938 11. Total time (years) spent in this occupation 35 yrs.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug. 20/ 1938

22. I HEREBY CERTIFY, That I attended deceased from July 28 1938, to August 20th 1938
 I last saw R.T. alive on Aug 19th 1938. Death is said to have occurred on the date stated above, at 2:30 P.M.
 The principal cause of death and related causes of importance were as follows:

Hepatic Abscess
 Date of onset May 1938
 Other contributory causes of importance: Valvular disease of heart 1935

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) San Luis Colorado

FATHER 13. NAME A. A. Salazar
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Abiqui New Mexico.

MOTHER 15. MAIDEN NAME Genoveva Gallegos
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Toas New Mexico.

17. INFORMANT (ADDRESS) Mrs. Harry Carpenter 7540 Maryland Ave.

18. BURIAL, CREMATION, OR REMOVAL PLACE San Luis, NEW Colorado Aug. 23/ 38

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Albert H. Hoppe, Inc. 429 N. Euclid Ave.

20. FILE AUG 21 1938 T. Q. Meyer M.D. Local Registrar.

Name of operation none Date of _____
 What test confirmed diagnosis? _____ 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? No
 If so, specify Henry J. Deonovian, M.D.
 (Signed) 707 (Address) 1256 Adams Ave. Kirkwood

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.

924

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

Registered Apprentice No., working under my personal supervision.

Signed *Robert W. Happe*

Licensed Embalmer No. *1861*

P. O. Address

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 this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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29944
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1. PLACE OF DEATH
 (a) County St. Louis Registration District No. 784
 (b) Township _____ Primary Registration District No. 101 Registered No. 1393
 (c) City Clayton (d) Street No. _____ St.
 (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 Rebecca S. Maloney
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m

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

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

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>61</u>	<u>10</u>	<u>29</u>	

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
 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) _____

FATHER 13. NAME _____
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

MOTHER 15. MAIDEN NAME _____
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) _____
 18. BURIAL, CREMATION, OR REMOVAL PLACE _____ DATE _____ 19.

19. FUNERAL DIRECTOR (ADDRESS) _____

20. FILED 821 1938 JR Mayor MD PRB Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 20 1938

22. I HEREBY CERTIFY, That I attended deceased from _____ 19____ to _____ 19____

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:
Hepatic abscess Date of onset _____
Bladder removed at
Kresney Hospital Denver Colo
92 d
 Other contributory causes of importance:
Valvular Disease of heart
Removal of Goiter at Denver
Colo. no tuberculosis

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

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? no trauma
 (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.
Abscess caused by obstruction of gall
 Manner of injury dent
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____
 (Signed) Henry J. Dionysius M. D.
 (Address) 125-F Adams ave
St. Louis

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

SUPPLEMENTAL

S-29944