

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

4520
Do not use this space.

REC'D MAR 13 1939

1. PLACE OF DEATH

(a) County..... Registration District No. 1003
 (b) Township..... Primary Registration District No. Registered No. 1213
 (c) City ST. LOUIS MO. (d) Street No. ST. John's Hospital 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 NORA MALONEY

(a) Residence, No. 2735 DALTON AV. St. 3 (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 FEMALE
 4. COLOR OR RACE WHITE
 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) JUNE 10-1877
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
65 7 26

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. HOUSEKEEPER
 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) MISSOURI

FATHER 13. NAME THOMAS MALONEY

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) IRELAND.

MOTHER 15. MAIDEN NAME KATHERINE HIGGINS

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) IRELAND.

17. INFORMANT (ADDRESS) MRS. Hugh ROBBY 2735 Dalton av

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE CALVARY CEM. FEB. 8, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) E. J. Schmu. 3125 Lafayette av.

20. FILED FEB 7 1939 J. B. Brudon Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-6, 1939

22. I HEREBY CERTIFY, That I attended deceased from June, 1938, to 2-6, 1939

Last saw h. in alive on 2-5, 1939. Death is said to have occurred on the date stated above, at 1:30 a.m.

The principal cause of death and related causes of importance were as follows:

Cerebral Hemorrhage (apoplexy)
Generalized Arteriosclerosis
and Hypertension
 Date of onset 12-5-39

Other contributory causes of importance:

None

Name of operation None Date of None
 What test confirmed diagnosis? Clinical 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

(Signed) John J. Hammond, M. D.
 (Address) 634 N. Grand Blvd.

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 Joseph Wollmer
Licensed Embalmer No. 4814
P. O. Address 3125 Lafayette Ave

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.