

FILED APR 15 1940

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 9513
2996
 Registrar's No. _____

791

Primary Registration District No. 1003

Registration District No. _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County _____

(b) City or town St. Louis?
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Deaconess Hospital.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution One Week!
(Specify whether in this community years, months or days)

3. (a) PRINT FULL NAME John P. Mooney.

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widower

6. (b) Name of husband or wife Bertha Mooney. 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Unknown 1865
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>75</u>	<u>Unknown</u>	<u>hr.</u>	<u>min.</u>

9. Birthplace Ireland 5
(City, town, or county) (State or foreign country)

10. Usual occupation Cafe Owner. Retired.

11. Industry or business _____

MOTHER FATHER { 12. Name Michael Mooney.

13. Birthplace Ireland. 5
(City, town, or county) (State or foreign country)

14. Maiden name Honorah Hughes.

15. Birthplace Ireland. 5
(City, town, or county) (State or foreign country)

16. (a) Informant CATHERINE MOONEY
 (b) Address 4218 FLAD AVE.

17. (a) Burial (b) Date thereof 4-1-1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calyary Cemetery

18. (a) Signature of funeral director Arthur J. Donnelly
 (b) Address 3840 Lindell Blvd.

19. (a) MAR 31 1940 (b) _____
(If received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County _____

(c) City or town St. Louis. 17
(If outside city or town limits, write "RURAL")

(d) Street No. 4218 Flad Ave.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 30th.
 year 1940 hour 12. minute 50 A.M.

21. I hereby certify that I attended the deceased from Dec. 26, 1939
 to Mar. 29 1940
 that I last saw him alive on Mar. 29 1940

and that death occurred on the date and hour stated above.

Immediate cause of death Hepatic Cirrhosis
Arteriosclerosis - Ch. hypoaorta 5 yrs +
Abdominal ascites 2 mo
 Due to Uremia due to Ch. Nephritis 1 mo?
Mild Diabetes Mel.

Due to _____

Other conditions 59
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy no

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work _____
(Specify type of place) (Means of injury)

23. Signature [Signature] (M. D. or other) MD
 Address 243501 Grand Date signed 3/30/40

Dr Johnson
2435 N Grand
1-3

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 *Stanley Marshall*

Licensed Embalmer No. *2868*

P. O. Address *3840 Lindell Blvd*

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.