

20725

FILED JUL 14 1942  
Registration District No. 83

Primary Registration District No. 1001

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD  
JUL 15 1942

1. PLACE OF DEATH:

(a) County Buchanan,

(b) City or town Saint Joseph,  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
2419 South 12th. Street,  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
years, months or days) 50 years,

In this community \_\_\_\_\_ (Specify whether  
years, months or days) 50 years,

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri, (b) County Buchanan

(c) City or town Saint Joseph,  
(If outside city or town limits, write "RURAL")

(d) Street No. 2419 South 12th. Street,  
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No) 0  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Della Mooney,

3. (b) If veteran, name war None,

3. (c) Social Security No. None,

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 11th:  
year 1942, hour 12:00 minute 20a.M.

21. I hereby certify that I attended the deceased on  
June 12 1942  
that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_  
and that death occurred on the date and hour stated above.

4. Sex Female / 5. Color or race White

6. (a) Single, widowed, married, divorced Widowed,

6. (b) Name of husband or wife Joseph A. Mooney, 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased December 24th. 1868  
(Month) (Day) (Year)

Immediate cause of death Cerebral Hemorrhage Duration 1 day

Due to General Arteriosclerosis

Due to \_\_\_\_\_

8. AGE: Years Months Days If less than one day

73 5 17 hr. \_\_\_\_\_ min.

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy no

9. Birthplace New York, New York,  
(City, town, or county) (State or foreign country)

10. Usual occupation At Home,

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

11. Industry or business \_\_\_\_\_

12. Name Watson Hallett,

13. Birthplace Unknown, 9  
(City, town, or county) (State or foreign country)

14. Maiden name Unknown, 9  
(City, town, or county) (State or foreign country)

15. Birthplace Unknown, 9  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. P. J. Johnson

(b) Address 2419 South 12th. Street,  
6/13/42

17. (a) Burial (b) Date thereof 6/13/42  
(Burial, cremation, or removal) (Month) (Day) (Year)

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? \_\_\_\_\_

(c) Place: burial, cremation St. Jo. Mem. Park Cem.

18. (a) Signature of funeral director Rowman Turner

(b) Address 319 So. 10th Street, Home

19. (a) 6-13-42 (b) Rose Herzog  
(Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place)

(a) Means of injury \_\_\_\_\_

23. Signature H. H. Mundy (M. D. coroner) Coroner

Address 404 So 39 Date signed 6/13/42

1295

**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..... *6-11-42*

....., Registered Apprentice No.....  
working under my personal supervision.

Signed *Wm. E. Dummerfield*

Licensed Embalmer No. *3007*

P. O. Address *319 S. 0.0 Joseph*

**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, fact should be so stated above.**