

Registration District No. **317**

Primary Registration District No. **3069**

Registrar's No. **422**

1. PLACE OF DEATH:

(a) County **St. Louis**
(b) City or town **Richmond Heights**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **St. Marv's Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **2 weeks**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Illinois** (b) County **Macon**
(c) City or town **Decatur**
(If outside city or town limits, write "RURAL")
(d) Street No. **1276 E. Orchard Ave.**
(If rural, give location)
(e) Citizen of foreign country? (Yes or No) **2**
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb.** day **16**
year **1944** hour **4:00** minute **P.** M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death: **Tumor of Brain (Malignant)**

Duration

Due to _____
Due to _____

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

Major findings: Of operations _____
Of autopsy **Same as above**

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?

23. Signature: **A. H. Hoppe, Inc.**
Address: **4700 Washington Blvd.**
Date signed: **Feb 18 1944**

3. (a) PRINT FULL NAME **JOHN MOLLOY**
3. (b) If veteran, name war **None**
3. (c) Social Security No. **Unknown**

4. Sex **Male**
5. Color or race **White**
6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Ruth Molloy**
6. (c) Age of husband or wife if alive **38** years
7. Birth date of deceased **Feb. 27 1902**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
41 11 19 hr. min.

9. Birthplace **Stillertown Illinois**
(City, town, or county) (State or foreign country)

10. Usual occupation **Baker**

11. Industry or business

MOTHER FATHER { 12. Name **John J. Molloy**
13. Birthplace **Alton Illinois**
(City, town, or county) (State or foreign country)
14. Maiden name **Lene Catherwood**
15. Birthplace **Assumption Illinois**
(City, town, or county) (State or foreign country)

16. (a) Informant **John Molloy**
(b) Address **Decatur, Illinois**

17. (a) **Removal** (b) Date thereof **2-17-44**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Decatur, Illinois**

18. (a) Signature of funeral director **Albert H. Hoppe, Inc.**
(b) Address **4700 Washington Blvd.**

19. (a) **FEB 18 1944** (b) **E. J. McKeever, M.D.**
(Date received local registrar) (Registrar's signature)

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

96
5
3

MAR 16 1944

MAR 23 1945

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.....

Albert G. Kappeler

Licensed Embalmer No.....

2971

P. O. Address.....

MAR 1 1944

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.