

No. 2  
-5-43  
5-17-39  
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THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 15808  
Registrar's No. 1063

FILED MAY 13 1944  
Registration District No. 13

Primary Registration District No. 3070

1. PLACE OF DEATH:

(a) County ST. LOUIS  
(b) City or town WEBSTER GROVES  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
824 TUXEDO BL. 1  
(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)

3. (a) PRINT FULL NAME CHARLES A. MOLLOY

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 MARRIED  
6. (b) Name of husband or wife CONSTANCE 6. (c) Age of husband or wife if alive 78 years  
7. Birth date of deceased SEPT. 21 1861  
(Month) (Day) (Year)

8. AGE: Years 82 Months 7 Days 16 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation ATTORNEY (RETIRED)

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

MOTHER FATHER { 12. Name WILLIAM MOLLOY  
13. Birthplace IRELAND (City, town, or county) (State or foreign country)  
14. Maiden name ELLEN M. MCCARTHY  
15. Birthplace KY (City, town, or county) (State or foreign country)

16. (a) Informant Ms. Constance Molloy

(b) Address 824 Tuxedo Bl.

17. (a) BURIAL (b) Date thereof MAY 10 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY CEM.

18. (a) Signature of funeral director L. Mullen and Co  
(b) Address 5165 Delmar Bl.

19. (a) MAY 10 1944 (b) C. J. Mc Gaven, M.D.  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St. Louis  
(c) City or town WEBSTER GROVES  
(If outside city or town limits, write "RURAL")  
(d) Street No. 824 TUXEDO BL. 1  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 7 year 1944 hour \_\_\_\_\_ minute 5:20 P.M.

21. I hereby certify that I attended the deceased from Dec 10 - May 9 1944 that I last saw him live on May 21 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary artery disease and vascular degeneration Duration 6 mo.  
Due to Coronary artery disease 2 years  
Due to arterio sclerosis and vascular degeneration 2 years  
Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy 9/0  
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) (2) Means of injury \_\_\_\_\_

23. Signature H. A. ... (M. D. or other) \_\_\_\_\_  
Address 19 E. ... Date signed 7/7/44

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

JUN - 5 1944

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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 John Ketter  
Licensed Embalmer No. 3880  
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, fact should be so stated above.**