

V. S. No. 2
100M-5-43
Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUN 19 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **19045**
Registrar's No. **5007**

Registration District No. **318** Primary Registration District No. **1003**

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

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1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Jewish Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4-days
In this community 25 yrs. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State California (b) County 999
(c) City or town Los Angeles
(If outside city or town limits, write "RURAL")
(d) Street No. N.R.
(If rural, give location)
(e) Citizen of foreign country? 2 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Carrie A. Morony
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month June day 5th., year 1945 hour 6 minute P. M.
21. I hereby certify that I attended the deceased from June 2, 1945, to June 5, 1945 that I last saw her alive on June 5, 1945 and that death occurred on the date and hour stated above.

4. Sex F. 5. Color or race W. 6. (a) Single, widowed, married, divorced, S. 0
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased: March 5th., 1875
(Month) (Day) (Year)

Immediate cause of death: A-V Heart Block
art. Electric Heart Disease?
Due to arterio-sclerosis?
Due to 93
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: _____
Of operations _____
Of autopsy _____

8. AGE: Years Months Days If less than one day
70 3 0 hr. _____ min.

9. Birthplace: Iowa /
(City, town, or county) (State or foreign country)
10. Usual occupation: At Home

11. Industry or business _____
12. Name Michael J. Morony
13. Birthplace Ireland /
(City, town, or county) (State or foreign country)
14. Maiden name Julia Shanahan
15. Birthplace Ireland /
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. F. J. Owens
(b) Address 523 West Rose Hill
17. (a) Removal (b) Date thereof 6-6-45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Pleasant, Iowa

18. (a) Signature of funeral director Arthur J. Donnelly
(b) Address 3840 Lindell Blvd.
19. (a) JUN 6 1945 (b) J. F. Budenz
(Date received local registrar) (Registrar's signature)

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) (c) Means of injury _____
23. Signature Arthur E. Straub (M. D. or other) _____
Address 539 N. 9th Date signed 6/6/45

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

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*.....

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.