No. 2
—8-43
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 31613

FILED OCT 9 1945

Registration District No. 16 · Primary Registration District No. 6237 · Registrar's No. 8

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

1. PLACE OF DEATH:
(a) County Warren
(b) City or town Hickory Grove (Rural) (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution Jump (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) In this community .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Warren 109
(c) City or town Rural (If outside city or town limits, write "RURAL")
(d) Street No. West of Wright City (If rural, give location)
(e) Citizen of foreign country? ..... (Yes or No) No
If yes, name country .....

3. (a) PRINT FULL NAME JAMES MARTIN MOONEY
3. (b) If veteran, name war ——
3. (c) Social Security No. 702-05-9990
4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Emma Mooney
6. (c) Age of husband or wife if alive 74 years
7. Birth date of deceased May (Month) 10 (Day) 1867 (Year)
8. AGE: Years 78 Months 5 Days 16 If less than one day ..... hr. ..... min.
9. Birthplace Warren Co (City, town, or county) Mo (State or foreign country)
10. Usual occupation Stationary Pumper (retired)
11. Industry or business .....
MOTHER FATHER
12. Name Tom Mooney
13. Birthplace Unknown (City, town, or county) 9 (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) 6 (State or foreign country)
16. (a) Informant Ira B. Mooney
(b) Address Wright City Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/28/45 (Month) (Day) (Year)
(c) Place: burial or cremation Warrenton Cem.
18. (a) Signature of funeral director Fieburg F & U Co.
(b) Address Wright City Mo.
19. (a) ..... (Date received local registrar) (b) ..... (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 26 year 1945 hour 5 minute 45 P.M.
21. I hereby certify that I attended the deceased from September 10, 1945, to Sept. 26, 1945 that I last saw him alive on Sept. 26, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Bronchial Pneumonia	5 days
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations .....
Of autopsy .....

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) (e) Means of injury .....
23. Signature John B. Kellum M.D. (M. D. or other)
Address Wright City, Mo. Date signed 9/27/45

1594

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed 10-8-45

DEC - 5 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 Julius J. Nilburg
Licensed Embalmer No. 3366
P. O. Address Wright City Mo

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.

S. No. 2B
1—8-21-41
Y29288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 0 A

Registration District No. 364 Primary Registration District No. 6237 Registrar's No. 8

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

1. PLACE OF DEATH:
(a) County: Warren
(b) City or town: Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(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)
In this community .....

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Warren
(c) City or town: Rural
(If outside city or town limits, write "RURAL")
(d) Street No.: West of Wright City
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME: James M. Mooney
3. (b) If veteran, name war: ✓
3. (c) Social Security No. 702-05-9190
4. Sex: M
5. Color or race: W
6. (a) Single, widowed, married, divorced: M
6. (b) Name of husband or wife .....
6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased: May 10 (Month) 86 (Day) (Year)
8. AGE: Years 48 Months 5 Days ..... If less than one day: ..... hr. ..... min.
9. Birthplace: Warren Co. (City, town, or county) Mo. (State or foreign country)
10. Usual occupation: Stationary Pumper (Retired)
11. Industry or business .....

MOTHER FATHER
12. Name: Tom Mooney
13. Birthplace: Unknown (City, town, or county) ..... (State or foreign country)
14. Maiden name: Unknown
15. Birthplace: Unknown (City, town, or county) ..... (State or foreign country)

16. (a) Informant: Ira M. Mooney
(b) Address: Wright City, Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/28/45 (Month) (Day) (Year)
(c) Place: burial or cremation: Warrenton Cem.
18. (a) Signature of funeral director: Nieburg F. & U. Co.
(b) Address: Wright City Mo
19. (a) 9/27/45 (Date received by local registrar) (b) Mrs. F. W. Hughes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September Day 6 year 1945 hour 5 minute 45 A.M.
21. I hereby certify that I attended the deceased from September 10 1945 to Sept. 26 1945 that I last saw him alive on September 26 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Bronchial Pneumonia	5 da.
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations .....
Of autopsy .....

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)
(b) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? ..... (c) Means of injury .....
23. Signature: John B. Killoran (M. D. or other)
Address: Wright City Mo. Date signed 9/29/45

SUPPLEMENTARY

DEC - 5 1945

31613