

S. No. 2
-12-45
5-17-39
P I X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **15442**
Registrar's No. **4052**

FILED MAY 1 1947

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

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

1. PLACE OF DEATH:
(a) County _____
(b) City or town **ST. LOUIS, MO.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **St. Louis City Hospital, Max C. Starkloff Memorial**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **3 months**
(Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo.** (b) County _____
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **4230 Castleman Ave.**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **WILLIAM 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 **Densy D. Molloy** 6. (c) Age of husband or wife if alive **62** years
7. Birth date of deceased **Nov. 14th 1879**
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **April** day **18** year **1947** hour **6:18** minute **a** M.
21. I hereby certify that I attended the deceased from **2-3-47** to **4-18-47**, 19____, and that death occurred on the date and hour stated above.
that I last saw h. **in** alive on **4-18-47**, 19____
Immediate cause of death _____

8. AGE: Years Months Days If less than one day
67 **5** **4** hr. _____ min.

Due to **Cerebral vasculer accident**
arteriosclerotic heart disease
Due to _____
Other conditions **Purpura with**
(Include pregnancy within 3 months of death)
Cerebral arteriosclerosis.

9. Birthplace **St. Louis Mo.**
(City, town, or county) (State or foreign country)
10. Usual occupation **Clerk- Post Office**
11. Industry or business _____
12. Name **Peter Richard Molloy**
13. Birthplace **St. Louis Mo.**
(City, town, or county) (State or foreign country)
14. Maiden name **Martha Morey**
15. Birthplace **Dont Know--New York**
(City, town, or county) (State or foreign country)

PHYSICIAN _____
Underline the cause to which death should be charged statistically.
Major findings: _____
Of operations _____
Of autopsy _____

16. (a) Informant **Richard Molloy**
(b) Address **4230 Castleman Ave.**
17. (a) **Burial** (b) Date thereof **4-21-47**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Calvary Cemetery**
18. (a) Signature of funeral director **Arthur J. Donnelly**
(b) Address **3840 Lindbergh Blvd**
19. (a) **1947** (b) **J. F. Bradley**
(Date of issue) (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) (e) Means of injury _____
3. Signature **Armedy in an** (M. D. or other) **red.**
Address **1515 Lafayette** Date signed **4-18-47**

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 W. Van Matre

Licensed Embalmer No. 2825

P. O. Address 4340 Lafayette

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.