

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-016229
STATE FILE NUMBER

FILED MAY 8 1959 Registration District No. 317 Primary Registration District No. 590 Registrar's No. 1224

300
-57

1. PLACE OF DEATH a. COUNTY St. Louis			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis			
b. CITY OR TOWN St. Ann's		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Ann's 4076		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION 10434 St. Chas Rd		Length of stay in lb 12 Yrs	d. STREET ADDRESS (If outside, give location) 10434 St. Chas. Rk. Rd.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Michael J Molloy			4. DATE OF DEATH Month Day Year May 1 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-28-1872	9. AGE (In years last birthday) 87 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Motorman		10b. KIND OF BUSINESS OR INDUSTRY Public Service	11. BIRTHPLACE (City and state or country) Ireland		12. CITIZEN OF WHAT COUNTRY? US A	
13a. FATHER'S NAME Patrick Molloy		13b. MOTHER'S MAIDEN NAME Mary Egan		14. NAME OF HUSBAND OR WIFE Mary Ann Molloy		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unk	17. INFORMANT Address Mary Ann Molloy 10434 St. Chas. Rk. Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Interio Sclerotic Heart Disease					INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b)			DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)				
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.						
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from 12-54 to May 159 and last saw ^{him} alive on 5/1/59 Death occurred at 4:50p. m on the date stated above; and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE L. Hayden M.D. (Degree or title)			22b. ADDRESS 730 Hodiamont		22c. DATE SIGNED 5/4/59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5-5-59	23c. NAME OF CEMETERY OR CREMATORY St. Peters Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis County, Mo.	
24. FUNERAL DIRECTOR ADDRESS J.W. Clark F.H. 1125 Hodiamont Ave.			25. DATE RECD. BY LOCAL REG. 5-4-59	26. REGISTRAR'S SIGNATURE John C. Murphy D.D.		

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases, injuries, etc., must be only stated as contributory to death. No 10 symptoms.

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~~....., Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Lawrence J. Herking*.....

Licensed Embalmer No. *4979*.....

P. O. Address *St. Louis, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.