

FILED AUG 14 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 25085
6740

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST LOUIS	
c. LENGTH OF STAY (in this place) 14 HRS		d. STREET ADDRESS (If rural, give location) 6015 1/2 SUBURBAN	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. JOHN'S HOSPITAL			

3. NAME OF DECEASED (Type or Print) WILLIAM J. MORIARTY	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) AUG. 7 1950
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5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH APRIL 15 '1872	9. AGE (In years) (In months) (In days) 78	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours	IF UNDER 15 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INSURANCE BROKER	10b. KIND OF BUSINESS OR INDUSTRY RETIRED	11. BIRTHPLACE (State or foreign country) KANSAS	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME MICHAEL JOSEPH MORIARTY	13b. MOTHER'S MAIDEN NAME MARY FOLEY	14. NAME OF HUSBAND OR WIFE ESTELA HAFER
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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. 499-26-3973	17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS W & M AM JOSEPH MORIARTY SAME
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 3 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Intestinal Obstruction		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Fecal Impostion DUE TO (c) Arteriosclerotic Heart disease II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Cardiac Insufficiency		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION No Operation	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 4. J. J. O.
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22. I hereby certify that I attended the deceased from 8/5 1950, to 8/7 1950, that I last saw the deceased alive on 8/7 1950, and that death occurred at 8:20 A.M., from the causes and on the date stated above.

23a. SIGNATURE James T. Houston, M.D. (Degree or title)	23b. ADDRESS 634 N. Grand	23c. DATE SIGNED 8/7/50
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE aug 10 1950	24c. NAME OF CEMETERY OR CREMATORY CALVARY	24d. LOCATION (City, town, or county) (State) ST LOUIS MO
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DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE AUG 8 1950 J. B. Fosater	25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS Street - Carroll 4600 Nat. L. Bridge
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 _____

working under my personal supervision.

Student Embalmer No.

Signed _____

Bernard Hoffman

Signed _____

Student Embalmer

Licensed Embalmer No. *4366*

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