MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

6823

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. 2060

Township ..... Primary Registration District No. 1003 Registered No. .....

City St Louis (No. 5614 Greer Ave St. ..... Ward)

2. FULL NAME Norine Meehan

(a) Residence. No. 5614 Greer Ave St., 6 Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Femal

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 31th 1907

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
19	3	28	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: House work

(b) General nature of industry, business, or establishment in which employed (or employer): at home

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY) St Louis Mo

PARENTS

10. NAME OF FATHER Patrick J Meehan

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Mo

12. MAIDEN NAME OF MOTHER Catherine Rice

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Mo

14. INFORMANT Catherine Meehan
(Address) 5614 Greer Ave

15. FILED MAR -2 1927 19 Max C Starkloff REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Febr 28 1927

17. I HEREBY CERTIFY, That I attended deceased from Jany 1 St., 1927, to Febr. 28th, 1927 that I last saw her alive on Febr 27th, 1927, and that death occurred, on the date stated above, at 1 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Myocarditis acute
108
93R
..... (duration) ..... yrs. ..... mos. 20 ds.

CONTRIBUTORY (SECONDARY) Unresolved pneumonia
Lobar (duration) ..... yrs. 1 mos. 10 ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? .....

0 DID AN OPERATION PRECEDE DEATH? No DATE OF .....

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) [signature], M. D

3/2/, 1927 (Address) 3900 Cleveland Av

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Calvary

DATE OF BURIAL: March 3 1927

20. UNDERTAKER: Cullen & Kelly

ADDRESS: 4526 Easton

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

...WITH UNFADING INK—THIS IS A PERMANENT RECORD

Dr D. D. O'Gorman
3900 Cleveland
Grand 0297