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

Do not use this space.

13398

1. PLACE OF DEATH

County ..... Registration District No. 791

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

City ..... (No. In Ambulance St. ..... Ward)

File No. .....

Registered No. 3725

2. FULL NAME Nora McCann

(a) Residence. No. 1527 Olive St., 25 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: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Divorced

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Unknown

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
abt 48				

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Seamstress
(b) General nature of industry, business, or establishment in which employed (or employer): Coal Shop
(c) Name of employer: Angelica

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY) Iowa

PARENTS

10. NAME OF FATHER — Unknown
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER —
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

14. INFORMANT Mr. R. Coryell
(Address) 1141 Pine St.

15. FILED APR 16 1927, 19 May C Starkeoff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 1st 1927

17. I HEREBY CERTIFY, That I attended deceased from Aug ....., 1926, to April, 1927 that I last saw her alive on April 1, 1927, and that death occurred, on the date stated above, at 12.10 A.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
41 E Cancer of Liver

44B

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (SECONDARY) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
8 DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) W. R. Coryell, M. D
, 19 (Address) 1141 Pine St.

*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: POTTERS FIELD.
DATE OF BURIAL: 4-19-1927

20. UNDERTAKER: E. Shanon, 1426 Carroll
ADDRESS

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