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.

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

672
Do not use this space.

3
1

1. PLACE OF DEATH FEB 12 1938
(a) County ~~(Jefferson)~~ St. Louis Mo Registration District No. 791
(b) Township ~~(Valle)~~ Primary Registration District No. 1003 Registered No. 528
(c) City ~~De Sota R.F.D.~~ (St. Louis Mo) (d) Street No. 5315 Delor St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Nora Kane 500
(a) Residence, No. De Sota Missouri St. NR De Sota Mo. R.F.D
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
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: Single
6. DATE OF BIRTH (MONTH, DAY, AND YEAR): June 2 1867
7. AGE: YEARS 70 MONTHS 7 DAYS 14 If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc. House work
10. Date deceased last worked at this occupation (month and year) Dec 1937
11. Total time (years) spent in this occupation Life

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Cork Ireland 5

FATHER
13. NAME Thomas Kane 5
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Cork Ireland 5

MOTHER
15. MAIDEN NAME Mary Kane
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Cork Ireland

17. INFORMANT (ADDRESS): John J. Donnelly 5315 Delor St. Louis Mo.,
18. BURIAL, CREMATION, OR REMOVAL
PLACE Clavary Cemetery DATE Jan 18-1938 19
19. FUNERAL DIRECTOR (ADDRESS): John J.A. Barrett 2819 North Union Bl'vd
20. FILED JAN 17 1938 19 J. F. Bredeck Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) JAN-16, 1938
22. I HEREBY CERTIFY, That I attended deceased from JAN-9, 1938, to JAN-16, 1938
I last saw her alive on JAN-9, 1938. Death is said to have occurred on the date stated above, at 5AM m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Bronchitis	
Chronic Nephritis	

Other contributory causes of importance:
Senility

Name of operation ..... Date of .....
What test confirmed diagnosis? Christ Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? No Date of injury ....., 19....
Where did injury occur? ..... (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury .....
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify .....
(Signed) David Ford, M. D.
(Address) De Sota Mo.

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I, Ablert G. Hoppe, Licensed Embalmer No. 2971

hereby certify that the body recorded on the reverse side of this certificate was embalmed by me

L. E.

No. or by Registered Apprentice No.

working under my personal supervision.

Signed Albert G. Hoppe

Licensed Embalmer No. 2971

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)