DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 31075

REC'D OCT 14 1939

Registration District No. 791

Primary Registration District No.

Registrar's No. 8138

1003

1. PLACE OF DEATH:

(a) County 1

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Louis City Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 1

(c) City or town St. Louis (If outside city or town limits, write "RURAL") 11

(d) Street No. 2513 Coleman St. (If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME John Noonan 556

3. (b) If veteran, name war none

3. (c) Social Security No. none

4. Sex male

5. Color or race White

6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Sept (Month) 10 (Day) 1874 (Year)

8. AGE: Years 65 Months Days 9 If less than one day hr. min.

9. Birthplace St. Louis Mo. (City, town, or county) (State or foreign country)

10. Usual occupation painter

11. Industry or business house painter

FATHER
12. Name Dennis Noonan
13. Birthplace Ireland (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Catherine Byrnes
15. Birthplace Ireland (City, town, or county) (State or foreign country)

16. (a) Informant's own signature John Noonan
(b) Address 620 Chenot St

17. (a) Calvary Cemetery (Burial, cremation, or removal) (b) Date thereof Sept 22 19 (Month) (Day) (Year)

(c) Place: burial or cremation St. Louis Mo.

18. (a) Signature of funeral director James J. Cullinane
(b) Address 1710 N. Grand

19. (a) SEP 21 1939 (Date received local registrar) (b) J. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 19th year 1939 hour 7:10 minute P M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death

Due to Lobar Pneumonia (Primary)

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (f) Means of injury

23. Signature Alfred Perry (M. D. or other)

Address Deputy Coroner Date signed 9/21/39

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

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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.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed Howard F. Rowland.

Licensed Embalmer No. 314

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, above space should be left blank.