

No. 2
1-2-43
5-17-39

DEPARTMENT OF COMMERCE
BUREAU OF VITAL STATISTICS
7 1945

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 25991

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 7413

1. PLACE OF DEATH:

(a) County St. Louis

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

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

(d) Length of stay: In hospital or institution 4-days (Specify whether)

In this community 4 1/2 years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 0 C. 1

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

(d) Street No. 4039 Greer Ave.
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Joseph P. Noonan

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 26th., year 1945 hour 2 minute 10 p.m.

4. Sex M. 5. Color or race W. 6. (a) Single, widowed, married, divorced S. (1)

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive 47 years

7. Birth date of deceased: March 11th., 1882
(Month) (Day) (Year)

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

Immediate cause of death: Fracture skull, laceration
Right side of brain, ruptured
at 4301 W. Lamar Blvd. Aug.
22, 1945 - about 5:35 PM

8. AGE: Years Months Days If less than one day

63 5 15 hr. _____ min.

9. Birthplace: St. Louis Mo. (1)
(City, town, or county) (State or foreign country)

Due to _____

Due to _____

Other conditions: _____
(Include pregnancy within 3 months of death)

10. Usual occupation: Carpenter

11. Industry or business: _____

12. Name: Michael Noonan

13. Birthplace: Ireland (4)
(City, town, or county) (State or foreign country)

14. Maiden name: Winifred O'Connell

15. Birthplace: Ireland (1)
(City, town, or county) (State or foreign country)

Major findings: _____
Of operations: _____

Of autopsy: ADDITIONAL SUPPLEMENTARY INFORMATION

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant: Miss Mary Noonan

(b) Address: 4039 Greer Ave.

17. (a) Burial (b) Date thereof: Aug 29
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Calvary

18. (a) Signature of funeral director: Arthur J. Bonnelly
(b) Address: 3840 Lindell Blvd.

19. (a) AUG 27 1945 (b) J. F. Brudeck
(Date received local registrar) (Registrar's signature)

22. If death was due to an accident, fill in the following:

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

(b) Date of occurrence: Aug 22 1945

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

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

While at work: _____ (Specify type of work)
(M. D. or other) see above

23. Signature: Arthur J. Bonnelly (M. D. or other) _____
Address: 4039 Greer Ave. Date signed: 8/27/45

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

M. B.
-M
AX I
D

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 Stanley Marshall

Licensed Embalmer No. 2868

P. O. Address 3840 Lindell?

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.

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. _____

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(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)

3. (a) PRINT FULL NAME Joseph P. Noonan

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced s

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased mar 1
(Month) (Day) (Year)

8. AGE: Years 63 Months 5 Days _____ If less than one day _____ hr. _____ min.

9. Birthplace _____
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____
(City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Data received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____
year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;

that I last saw him _____ alive on _____, 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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

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

(b) Date of occurrence Aug 22 1945

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

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

While at work? _____
(Specify type of place) (Means of injury) fall down steps

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

Address St. Louis Date signed _____

SUPPLEMENTARY 6

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

MOTHER, FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

25991