S. No. 2
OM—2-43
v. 5-17-39
P I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

25993

State File No.

FILED SEP 7 1945

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7511

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17
4

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: 2034 Russell
(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 000

(c) City or town St. Louis 1723
(If outside city or town limits, write "RURAL")

(d) Street No. 2034 Russell 9
(If rural, give location)

(e) Citizen of foreign country? no 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Nordman, Lillie K.

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex female/

5. Color or race white

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

6. (b) Name of husband or wife Chas. H. Nordman

6. (c) Age of husband or wife if alive 85 years

7. Birth date of deceased May (Month) 2 (Day) 1868 (Year)

8. AGE: Years 77 Months 3 Days 25 If less than one day hr. min.

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

10. Usual occupation housewife

11. Industry or business

FATHER
12. Name Bailey
13. Birthplace unknown (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name unknown
15. Birthplace unknown (City, town, or county) U (State or foreign country)

16. (a) Informant Mr. Chas. H. Nordman

(b) Address 2034 Russell

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 8-30-45 (Month) (Day) (Year)

(c) Place: burial or cremation New St. Marcus Cemetery

18. (a) Signature of funeral director Witt Bros. L. & U. Co.

(b) Address 2929 S. Jefferson

19. (a) AUG 29 1945 (Date received by local registrar) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 27 year 1945 hour 5:30 minute P.M.

21. I hereby certify that I attended the deceased from about 6-15-42, 19 to 8-27-45, 19; that I last saw h. alive on 8-24-45, 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Acute myocarditis	about 3 da
Due to Chr. myocarditis	about 3 yrs
Due to (age 77 yrs)	
Other conditions (Include pregnancy within 3 months of death)	

930

Major findings: Of operations None

Of autopsy None

about pt. is all 3 by from Lenehan

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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

(b) Date of occurrence X

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

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

While at work? X (Specify type of place) X (e) Means of injury X

23. Signature John B. Lynn M.D. (M. D. or other)

Address 1715 Pine Date signed 8-29-45

(Licensed Embalmer's Statement on Reverse Side)

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 Frank Prokopf

Licensed Embalmer No. 4356

P. O. Address.....

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.