V. S. No. 2
00M—5-43
ev. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 6 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 29294

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8304

1. PLACE OF DEATH:

(a) County
(b) City or town St Louis Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 3519 A MIAMI ST /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 65 Years In St Louis (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 17 16
(If outside city or town limits, write "RURAL")
(d) Street No. 3519 A Miami 0
(If rural, give location) 1
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME ANNA NORRIS

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 Widow 7
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased AUG 6th 1872 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
73	1	17	hr. min.

9. Birthplace Ireland (City, town, or county) 4 (State or foreign country)
10. Usual occupation At Home
11. Industry or business Housewife

FATHER
12. Name ?Noonan
13. Birthplace Ireland (City, town, or county) 4 (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Ireland (City, town, or county) 11 (State or foreign country)

16. (a) Informant ANNA GAHN
(b) Address 3519 A MIAMI ST
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 26 /45 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary
18. (a) Signature of funeral director Theo Kutis & Son
(b) Address 2900 Gravois Ave.
19. (a) (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

SEP 25 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 23 year 1945 hour 5 15 P.M. minute M.
21. I hereby certify that I attended the deceased from 9-10-45, 1945, to 9-10, 1945; that I last saw her alive on 9-10-45, 19; and that death occurred on the date and hour stated above.

Immediate cause of death Senility
Arteriosclerosis, generalized.
Due to
Due to 97
Other conditions none
(Include pregnancy within 3 months of death)
Major findings:
Of operations None
Of autopsy None

Duration

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

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? (e) Means of injury

23. Signature E P Scott M.D. (M. D. ~~or other~~)
Address 3258 Lafayette, City Date signed 9-25-45

(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 David Van Fossan

Licensed Embalmer No. 4242

P. O. Address 2906 Harris Ave.

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.