

S. No. 2
 OM-5-43
 v. 5-17-39
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DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

42479/

FILED JAN 5 1946

State File No.

Registration District No. 317

Primary Registration District No. 6076

Registrar's No. 2967

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

1. PLACE OF DEATH:
 (a) County St. Louis
 (b) City or town Lemay
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
358 Hoffmeister ave.
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County St. Louis
 (c) City or town Lemay
(If outside city or town limits, write "RURAL")
 (d) Street No. 358 Hoffmeister ave.
(If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Henry Noll
 3. (b) If veteran, name war no
 3. (c) Social Security No. 493-01-5323

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month December day 27
 year 1945 hour 6 minute 15 A. M.
 21. I hereby certify that I attended the deceased from December 24th, 19 45,
 that I last saw him alive on December 26th, 19 45
 and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race White
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Barbara Noll
 6. (c) Age of husband or wife if alive 65 years
 7. Birth date of deceased September 9 1875
(Month) (Day) (Year)

Immediate cause of death Chronic Myocarditis
 Duration 5 yrs.
 Due to _____
 Due to _____

| 8. AGE: | Years | Months | Days | If less than one day |
|---------|-----------|----------|-----------|----------------------|
| | <u>70</u> | <u>3</u> | <u>18</u> | hr. min. |

Other conditions (Include pregnancy within 3 months of death)
Nasopharyngitis - acute
 Major findings:
 Of operations _____
 Of autopsy _____

9. Birthplace Germany
(City, town, or county) (State or foreign country)
 10. Usual occupation Retired

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

11. Industry or business _____
 12. Name George Noll
 13. Birthplace Germany
(City, town, or county) (State or foreign country)
 14. Maiden name Mary Foulk
 15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant Barabara Noll
 (b) Address 358 Hoffmeister ave.
 17. (a) Burial (b) Date thereof Dec. 29, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Sunset' burial Pa rk

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? _____

18. (a) Signature of funeral director C. Hoffmeister U. & S. Co.
 (b) Address 7814 S. Broadway
 19. (a) 12-29-45 (b) [Signature]
(Date received local registrar) (Registrar's signature)

While at work? _____ Means of injury? _____
 23. Signature Frank Cleary (M. D. or other) MD
 Address 1935 Park Ave., St. Louis, Mo. Date signed 12/27/45

Dr. Cleary

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 Linus C. Hoffmeister

Licensed Embalmer No. 3871

P.O. Address 7814 S Broadway

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.