

21946 STANDARD CERTIFICATE OF DEATH

State File No. 7182

FILED MAR 317

Registrar's No. 515

Registration District No. 317

Primary Registration District No. 6076

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town Baden Station 4  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Halls Ferry Memorial Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2 1/2 Months.  
(Specify whether  
In this community  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Gas  
(c) City or town St. Louis 17  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4119 Shaw Avenue. 9  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No) 1  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Samuel A. Van Nort.

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 Widowed  
6. (b) Name of husband or wife Addie St. Clair Van Nort 6. (c) Age of husband or wife if alive Dec'd years  
7. Birth date of deceased August 29, 1853.  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
92 5 27 hr. min.

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

10. Usual occupation Retired Electrical Contr.

11. Industry or business

12. Name William Van Nort.  
13. Birthplace Virginia.  
(City, town, or county) (State or foreign country)  
14. Maiden name Sarah Cissel.  
15. Birthplace Virginia.  
(City, town, or county) (State or foreign country)

MOTHER FATHER

16. (a) Informant Mr. A. Wallace Van Nort.

(b) Address 4119 Shaw Avenue.

17. (a) Burial (b) Date thereof 2-28-1946.  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bellefontaine Cemetery.

18. (a) Signature of funeral director Geo. L. Pleitsch, Inc.

(b) Address 5966-68 Easton Avenue.

19. (a) 3-1-46 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 25th.  
year 1946 hour 5 minute 20 P.M.

21. I hereby certify that I attended the deceased from Dec 12 1945 to Feb 25 1946  
that I last saw him alive on Feb 20 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of bladder

Due to 32

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Includes 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) \_\_\_\_\_

(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?  
\_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)  
( ) Means of injury \_\_\_\_\_

23. Signature [Signature] (M. D. or other) \_\_\_\_\_

Address [Address] Date signed 2-26-46

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

0132

Dr. Nellie Shaver.  
2739 N. Grand Ave.  
Hours 2 to 6 P.M.  
Telephone Jefferson 4271

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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

*Clement McPeay*

Licensed Embalmer No.

*3732*

P. O. Address

*St. Louis*

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.