

Registration District No. 318Primary Registration District No. 1003Registrar's No. 2199

## 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: De Paul Hospital  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 24 days.  
 (Specify whether  
 In this community  
 years, months or days)

3. (a) PRINT FULL NAME John F. Noonan.3. (b) If veteran, name war World War #1 3. (c) Social Security No. 498-14-60854. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married.6. (b) Name of husband or wife Clara L. Noonan. 6. (c) Age of husband or wife if alive 42 years7. Birth date of deceased January 18, 1890.  
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day  
56 1 16 hr. min.9. Birthplace St. Louis, Missouri  
(City, town, or county) (State or foreign country)10. Usual occupation Stock Clerk11. Industry or business Western Auto Supply.12. Name Michael Noonan.13. Birthplace Ireland  
(City, town, or county) (State or foreign country)14. Maiden name Mary McGrath15. Birthplace Kirkwood, Mo.  
(City, town, or county) (State or foreign country)16. (a) Informant Mrs. Clara L. Noonan.(b) Address 5986a Highland Avenue.17. (a) Burial (b) Date thereof 3-7-1946.  
(Burial, cremation, or removal) (Year)(c) Place: burial or cremation Jefferson Barracks, Mo.18. (a) Signature of funeral director Geo. L. Pleitsch, Inc.(b) Address 5966-68 Easton Avenue.19. (a) MAR 6 1946 (b) J. F. Brodeur  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis  
 (c) City or town St. Louis (12)  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 5986a Highland Avenue.  
 (If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 4th.  
year 1946 hour 9 minute 15 P.M.21. I hereby certify that I attended the deceased from 12-18, 1945 to 3-4, 1946.  
that I last saw him alive on 3-4, 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_ Duration \_\_\_\_\_

Due to Carcinoma of BronchusDue to Metastasis to LungsOther conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)Major findings: Of operations NoneOf autopsy Yes - found as above

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) (e) Means of injury \_\_\_\_\_

23. Signature W. E. Moore (M. D. or other) MD  
Address 2801 Central Bridge Date signed 3-5-46

Dr. W. Moore.  
7301 Natural Bridge Road.  
Hours 3 to 5 P.M.  
Telephone 4064 Mulberry

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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

*John Ketter*

Licensed Embalmer No.

*3880*

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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. *April*

Registration District No. *318*

Primary Registration District No. *1003*

Registrar's No. *2199*

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:  
(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)

3. (a) PRINT FULL NAME *John J. 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 *m*

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

7. Birth date of deceased *Jan 19 1946*  
(Month) (Day) (Year)

8. AGE: Years *56* Months Days If less than one day hr. min. *no*

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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (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 *10* Day *10* Year *1946* Hour *10* minute *15* M.

21. I hereby certify that I attended the deceased from *10* 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 *Carcinoma of Rt Bronchus*

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations Of autopsy *470*

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) (2) Means of injury

23. Signature *W. B. Moore* (M. D. or other) *MD*  
Address *7301 Natural Bridge* Date signed *11/5/46*  
*Normandy Mo*

SUPPLEMENTARY

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

10470

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

11498

U.S. DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.