S. No. 2
M—5-43
5-17-39
I   X36671

**DEPARTMENT OF COMMERCE**
BUREAU OF THE CENSUS

**THE STATE BOARD OF HEALTH OF MISSOURI**

FILED MAY 27 1946 **STANDARD CERTIFICATE OF DEATH**

State File No. ............ **18761**

Registration District No. ........ **318**   Primary Registration District No. ........ **1003**   Registrar's No. ........ **4382**

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

| 1. PLACE OF DEATH: | 2. USUAL RESIDENCE OF DECEASED: |
|---|---|
| (a) County........ ST. LOUIS | (a) State ILLINOIS  (b) County RANDOLPH |
| (b) City or town........ ST LOUIS | (c) City or town........ RED BUD |
| (If outside city or town limits, write "RURAL" and name of township) | (If outside city or town limits, write "RURAL") |
| (c) Name of hospital or institution: STONE NURSING HOME | (d) Street No. RR # 1 |
| (If not in hospital or institution, write street number or location) | (If rural, give location) |
| (d) Length of stay: In hospital or institution 18 DAYS | (e) Citizen of foreign country?............  (Yes or No) |
| In this community 18 DAYS | If yes, name country............ |
| years, months or days | |

**MEDICAL CERTIFICATION**

3. (a) PRINT FULL NAME    MARY JANE NOONAN

20. DATE OF DEATH: Month MAY   day 14th   year 1946   hour 11:30 PM minute ............ M.

3. (b) If veteran, name war    —

3. (c) Social Security No.    —

21. I hereby certify that I attended the deceased from April 28, 1946, to May 17, 1946, that I last saw her alive on May 12, 1946 and that death occurred on the date and hour stated above.

4. Sex FEMALE   5. Color or race WHITE   6. (a) Single, widowed, married, divorced SINGLE

Immediate cause of death  Cerebral Hemorrhage   Duration

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

Due to  Arteriosclerosis

7. Birth date of deceased DEC. 17 1866
(Month) (Day) (Year)

Due to  Degeneration of Brain

| 8. AGE: | Years | Months | Days | If less than one day |
|---|---|---|---|---|
| | 79 | 4 | 27 | hr. ...... min. ...... |

Other conditions  Senile Psychosis
(Include pregnancy within 3 months of death)  Simple deterioration

Major findings: Of operations............

9. Birthplace RED BUD ILL
(City, town, or county)   (State or foreign country)

10. Usual occupation............

11. Industry or business RETIRED

Of autopsy............

FATHER { 12. Name DANIEL NOONAN

PHYSICIAN

13. Birthplace IRELAND
(City, town, or county)   (State or foreign country)

Underline the cause to which death should be charged statistically.

MOTHER { 14. Maiden name JANE DONAHUE

15. Birthplace IRELAND
(City, town, or county)   (State or foreign country)

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

16. (a) Informant LORETTA NOONAN

(a) Accident, suicide, or homicide (specify) no

(b) Address 5105 MINERVA AV

(b) Date of occurrence no

(c) Where did injury occur? no
(City or town)   (County)   (State)

17. (a) REMOVAL   (b) Date thereof 5-15-1946
(Burial, cremation, or removal)   (Month) (Day) (Year)

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

(c) Place: burial or cremation ST PATRICK CEM Tiptown Ill.

18. (a) Signature of funeral director KOCH & SON FUNERAL HOME
While at work?............   (e) Means of injury............
(Specify type of place)

(b) Address RED BUD ILL

MAY 15 1946   J F Bredech

23. Signature S W Myxxxxder (M. D. or other) M.D.

19. (a) MAY 15 1946   (b)
(Date received local registrar)   (Registrar's signature)

Address 6453 Chippewa   Date signed May 25
St Louis

(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............................ _John Ketter_ ..........................

Licensed Embalmer No.......... 3880 ................................

P. O. Address............ St. Louis Mo ...........

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.