S. No. 2
—1/47
5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 25893

FILED JUL 21 1947

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 6567

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

1. PLACE OF DEATH:

(a) County

(b) City or town ST. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Alexian Bros. Hosp.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 weeks (Specify whether In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Ado

(c) City or town ST. Louis 17
(If outside city or town limits, write "RURAL")

(d) Street No. 2334 S. 13th 9
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 0

If yes, name country

3. (a) PRINT FULL NAME George Dana Noonan

3. (b) If veteran, name war None

3. (c) Social Security No. 134-03-5266

4. Sex Male

5. Color or race W

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Wife Manette F. Noonan

6. (c) Age of husband or wife if alive 56 years

7. Birth date of deceased April (Month) 3 (Day) 1885 (Year)

8. AGE: Years 62 Months 3 Days 8 If less than one day hr. min.

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

10. Usual occupation Auto accessories

11. Industry or business C. L. Hartmann Corp.

FATHER
12. Name Eneas Noonan
13. Birthplace ST. Louis, (City, town, or county) Missouri (State or foreign country)

MOTHER
14. Maiden name Sue LeSeur
15. Birthplace Alton (City, town, or county) Ill. (State or foreign country)

16. (a) Informant Manette F. Noonan
(b) Address 2334 S. 13th

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof July 14, 1947 (Month) (Day) (Year)
(c) Place: burial or cremation St. Paul Churchyard

18. (a) Signature of funeral director Witt Bros. L & U. Co.
(b) Address 2929 S. Jefferson Ave.

19. (a) JUL 12 1947 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 7 year 1947 hour 1 minute 17 M.

21. I hereby certify that I attended the deceased from November 20, 1946 to July 11-1947 that I last saw him alive on July 11, 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Chronic Myocarditis	1 year
Due to: Coronary Thrombosis	7 mo.
Due to:	
Other conditions (Include pregnancy within 3 months of death): None	

Major findings:
Of operations None
Of autopsy None

PHYSICIAN
Underline the cause of 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) 0

While at work? (e) Means of injury

23. Signature Julius Chas Roller (M. D. or other) M.D.

Address 2603 Cherokee Date signed 7-11-1947

Jefferson City Printing Co.

(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 D. M. Davis

Licensed Embalmer No. 3741

P. O. Address 2929 So Jefferson

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.

S. No. 2B
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. Primary Registration District No. Registrar's No.

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

1. PLACE OF DEATH:

(a) County

(b) City or town (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Alexian Bros Hosp.
(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)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County

(c) City or town St Louis (If outside city or town limits, write "RURAL")

(d) Street No. 2334 S. 13th St (If rural, give location)

(e) Citizen of foreign country (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME George Dana 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 Married

6. (b) Name of husband or wife

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

7. Birth date of deceased 4 (Month) — 3 (Day) — 1885 (Year)

8. AGE: Years 62 | Months 3 | Days 4 | If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER

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) J. F. Bredeck (Registrar's signature)

OCT 18 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day (11) year 1947 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ;

that I last saw h alive on , 19 ;

and that death occurred on the date and hour stated above.

Immediate cause of death — Duration

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

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 (M. D. or other)

Address Date signed

SUPPLEMENTARY

S-25893