

FILED DEC 22 1947
Registration District No. 1003

Primary Registration District No. 1003

State File No. _____
Registrar's No. 11376

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..... *5073 Waterman Ave.*
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution..... *60 years*
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... *MO.* (b) County..... *St. Louis*

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

(d) Street No..... *5073 Waterman Ave.*
(If rural, give location)

(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME..... *Lillian Nolan*

3. (b) If veteran, name war.....

3. (c) Social Security No.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... *Dec.* day..... *11th.*,
year..... *1947* hour..... *5* minute..... *15* p. M.

4. Sex..... *F.* 5. Color or race..... *W.*

6. (a) Single, widowed, married, divorced..... *S.*

6. (b) Name of husband or wife.....

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

7. Birth date of deceased..... *Unk. Unk. 1867*
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from..... *July 1 - 47*
to..... *Dec 11 1947*
that I last saw him..... *alive on Dec 11 1947*
and that death occurred on the date and hour stated above. *Durand*

8. AGE: Years..... *abt - 80* Months..... *unk.* Days..... *unk.*
If less than one day hr. min.

Immediate cause of death..... *Chronic myocarditis*

Due to..... *Chronic myocarditis*

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

10. Usual occupation..... *At Home*

Due to..... *Chronic myocarditis*

Other conditions..... *95*
(Include pregnancy within 3 months of death)

11. Industry or business.....

12. Name..... *Matthew Nolan*

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

14. Maiden name..... *Margaret Nolan*

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

PHYSICIAN..... *95*

Major findings:
Of operations.....

Of autopsy.....

Underline the cause of which death should be charged statistically.

16. (a) Informant..... *Miss Jane Nolan*

(b) Address..... *5073 Waterman Ave.*

17. (a) *Burial*
(Burial, cremation, or removal)

(b) Date thereof..... *12-13-47*
(Month) (Day) (Year)

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?.....

(c) Place: burial or cremation..... *Cavary*

18. (a) Signature of funeral director..... *Arthur J. Donnelly*

(b) Address..... *3840 Lindell Blvd.*

19. (a) (Date received local registrar)..... *DEC 12 1947*

(b) Registrar's signature..... *J. F. Bredebeck*

(e) Signature of physician..... *Arthur J. Donnelly* (M. D. or other)

Address..... *114 W. 7th St.* Date signed..... *12/12/47*

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

MOTHER FATHER

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 Stanley Marshall

Licensed Embalmer No. 2868

P. O. Address 3840 Lindell

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.