

FILED MAY 17 1954

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 17255

BIRTH NO. 33797-54 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 4227

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
c. LENGTH OF STAY (in this place) 7 hrs 10 min		d. STREET ADDRESS (If rural, give location) 21 2927 Lawton	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips		2219	
3. NAME OF DECEASED (Type or Print) (Twin# 1)		4. DATE OF DEATH (Month) (Day) (Year) 5 1 54	
a. (First)		b. (Middle)	
c. (Last) Nolan			
5. SEX Fem.	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH 5-1-54
9. AGE (In years last birthday)	10. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Missouri	12. CITIZEN OF WHAT COUNTRY?
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
13a. FATHER'S NAME Guy Ben Nolan	13b. MOTHER'S MAIDEN NAME Mary Lee Bridger	14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Arthur M. Sherrard R.R. 2601 N. Whittier	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		ADDRESS	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		MEDICAL CERTIFICATION	
PREMATURE BIRTH, NEONATAL DEATH		INTERVAL BETWEEN ONSET AND DEATH	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.			
II. OTHER SIGNIFICANT CONDITIONS			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 776x	
22. I hereby certify that I attended the deceased from 5-1-1954, to 5-1-1954, that I last saw the deceased alive on 5-1-54, and that death occurred at 9:00 A.M., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) William B. Ankler M. D.		23b. ADDRESS 2601 N. Whittier	
23c. DATE SIGNED 5-5-54			
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 5-31-54	24c. NAME OF CEMETERY OR CREMATORY Anatomical Bvau	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.
DATE REC'D BY LOCAL REG. MAY 11 1954	REGISTRAR'S SIGNATURE J. Carl Smith Mo	25. FUNERAL DIRECTOR'S SIGNATURE Rowland-Aker Mortuary Service	

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300
10-48

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

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.