

FILED FEB 8 - 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **43883**  
Registrar's No. **11827**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>St Louis</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>ST. LOUIS, MISSOURI</b>		c. LENGTH OF STAY (In this place)	c. CITY OR TOWN <b>Claytons</b> d. Is Residence within limits of city or incorporated town? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b>		STREET ADDRESS (If rural, give location) <b>9187 Clayton Road</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>ANNA</b> b. (Middle) <b>MAY</b> c. (Last) <b>NOLLNER</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>December 27, 1954</b>		
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>single</b>	8. DATE OF BIRTH <b>August 3, 1890</b>	9. AGE (In years last birthday) <b>64</b>	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maplewood High</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Creve Coeur, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>

13a. FATHER'S NAME <b>George W. Nollner</b>	13b. MOTHER'S MAIDEN NAME <b>Sadina Pehle</b>	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Dr. Thomas H. Burford</b>	ADDRESS <b>600 S. Kingshighway</b>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 yrs.</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Carcinoma of Left Breast with Metastases</b>		
	II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>		
ANTECEDENT CAUSES <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i>		DUE TO (b) _____ DUE TO (c) _____	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>170X</b>
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22. I hereby certify that I attended the deceased from **9-29-**, 19 **54**, to **12-27-**, 19 **54** that I last saw the deceased alive on **12-27-**, 19 **54**, and that death occurred at **1:35 Pm.**, from the causes and on the date stated above.

23a. SIGNATURE <i>C. P. Vermillion, M.D.</i> (Degree or title) <b>M. D.</b>	23b. ADDRESS <b>BARNES HOSPITAL</b>	23c. DATE SIGNED <b>12-27-54</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>12-29-54</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Old Cem. on Bway</b>	24d. LOCATION (City, town, or county) (State) <b>Columbia, Missouri</b>
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DATE REC'D BY LOCAL REG. <b>DEC 28 1954</b>	REGISTRAR'S SIGNATURE <i>J. Carl Smith</i>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Alexander &amp; Sons</b>	ADDRESS <b>6175 Delmar Blvd.</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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 ....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Stanley A. Dixon*

Licensed Embalmer No. *4193*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.