

FILED JAN 27 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **44335**
Registrar's No. **3016**

BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **500**

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Louis	
b. CITY OR TOWN Normandy		c. CITY OR TOWN Normandy	
d. FULL NAME OF HOSPITAL OR INSTITUTION O'Sullivan Nursing Home		STREET ADDRESS (If rural, give location) 3715 St. Ann's Lane	

3. NAME OF DECEASED (Type or Print) Sadie	a. (First) L	b. (Middle) Noel	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) 12/29/54
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 12/25/1894	9. AGE (In years last birthday) 50	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 1 HRS. Hours	IF UNDER 15 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework	10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME William J Parker	13b. MOTHER'S MAIDEN NAME Miller	14. NAME OF HUSBAND OR WIFE Wesley Noel Dec.
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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) No	16. SOCIAL SECURITY NO. Unk	17. INFORMANT'S SIGNATURE OR NAME Lillian Iverson	ADDRESS 1234a Shawmut Pl
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhages		INTERVAL BETWEEN ONSET AND DEATH 1 year
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertensive Cerebral Vascular disease		
	DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			unknown

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 331x	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **Dec 9, 1953**, to **Dec 29, 1954**, that I last saw the deceased alive on **Dec 27, 1954**, and that death occurred at **9:30a m.**, from the causes and on the date stated above.

23a. SIGNATURE Louis Littmann MD	(Degree or title)	23b. ADDRESS 8231 Clayton Rd (17)	23c. DATE SIGNED 12/30/54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 12/31/54	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis Missouri
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DATE REC'D BY LOCAL REG. 12-30-54	REGISTRAR'S SIGNATURE Herbert R. Donker M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Jos. W. Clark	ADDRESS 1125 Hodiament Ave.
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WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD

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.....

Alfred J. Brecken

Licensed Embalmer No. *266*

P. O. Address *1125/H*

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.