

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-003924

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 383

FILED JAN 17 1963		
1. PLACE OF DEATH a. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		
Length of stay in lb <u>3 wks</u>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Johns Hospital</u>		
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>		
c. CITY OR TOWN <u>University City</u>		
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
d. STREET ADDRESS (If outside, give location) <u>1719 Crystal Ct.</u>		
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>Anna A. Nolan</u>		
4. DATE OF DEATH Month Day Year <u>Jan. 12 1963</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>
8. DATE OF BIRTH <u>8/12/1896</u>		9. AGE (last birthday) <u>66</u>
IF UNDER 1 YEAR Months Days		IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>
11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.A.A.</u>
13a. FATHER'S NAME <u>George Weber</u>		13b. MOTHER'S MAIDEN NAME <u>Elizabeth Vogel</u>
14. NAME OF HUSBAND OR WIFE <u>Robert E. Nolan</u>		Address
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>3</u>
17. INFORMANT <u>Robert E. Nolan</u>		Address <u>1719 Crystal Ct</u>
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY) IMMEDIATE CAUSE (a) <u>Adenocarcinoma colon</u>		
DUE TO (b) _____		
DUE TO (c) <u>153.8</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Bronchopneumonia, terminal</u>		
PART III. If deceased was female was there a pregnancy in last 90 days <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21. I attended the deceased from <u>Mar 24 56</u> to <u>Jan 12 63</u> and last saw her <u>live on</u> <u>Jan 11 '63</u> Death occurred at <u>2:45 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <u>H.H. Sessener MD</u>	(Degree or title)	22b. ADDRESS <u>206 Northland Med Bldg</u>
22c. DATE SIGNED <u>1-12-63</u>	23. LOCATION (City, town, or county) (State) <u>St. Louis Missouri</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>1/14/63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary</u>
24. FUNERAL DIRECTOR <u>Ortmann F. Home</u>		25. DATE RECD. BY LOCAL REG. <u>JAN 14 1963</u>
26. REGISTRAR'S SIGNATURE <u>Loal Smith, M.D.</u>		

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED	AMENDED	INSTEAD OF	DOCUMENT
3			
4	1		
5	1		
6			
7	0		
8	2		
9			
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11			
12	74		
13			
ITEM NO.	SHOULD READ	BY AFFIDAVIT OF	

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 Cl C Ostmann

Licensed Embalmer No. 3478

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.