MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

1235

1. PLACE OF DEATH
County Jackson
Township Kaw
City K.C. Mo.
Registration District No. 399
Primary Registration District No. 1002
(No. Research Hosp. St. Ward)
File No. 282
Registered No. 282

2. FULL NAME John H. Noland
(a) Residence. No. 6525 Edgevale Rd. St. Ward.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M.
4. COLOR OR RACE Wh.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Lettie Noland

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec-5-1889

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ___ hrs. or ___ min.
37	1	13	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Auditor
(b) General nature of industry, business, or establishment in which employed (or employer) Lang Creamery
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Ky
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER Joseph Noland
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ky
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Milvina Johnson
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ky
(STATE OR COUNTRY)

14. INFORMANT Mrs. Lettie Noland
(Address) 6525 Edgevale Rd.

15. FILED Jan 20 1927 M. M. Crowe Asst. REGISTRAR
Jan 2613

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 18 1927

17. I HEREBY CERTIFY, That I attended deceased from Sept 24, 1926, to Jan 18, 1927, that I last saw him alive on Jan 18, 1927, and that death occurred, on the date stated above, at 1:05 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Diabetic Coma
54
57
(duration) yrs. mos. 1 ds.

CONTRIBUTORY (SECONDARY)
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? Research Hosp
DID AN OPERATION PRECEDE DEATH? no DATE OF —
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Test usual for diabetes
(Signed) Rave Jennings, M.D.
1/19, 1927 (Address) 1334 Rialto

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Louisville, Ky
DATE OF BURIAL 1-20 1926

20. UNDERTAKER Mrs. C. L. Forster
ADDRESS K.C. Mo.

WRITE PLAINLY, UNFADING INK---THIS IS PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Tavis.
Rialto
96

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
County Jackson — Registration District No. 399 — File No.
Township — Primary Registration District No. 1002 — Registered No. 282
City Kansas City, Mo. (No. ..... St. ..... Ward)

2. FULL NAME John H. Noland
(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE — YEARS — MONTHS — DAYS — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

14. INFORMANT .....
(Address)

15. FILED Jan 20 1927 M. M. Crowe Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 18, 1927

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
.....
.....
.....
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) ....., M. D
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL — DATE OF BURIAL 1/20 1927

20. UNDERTAKER — ADDRESS

SUPPLEMENTARY

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.—Every item of information [illegible] carefully supplied. AGE should [illegible] EXACTLY. PHYSICIANS should [illegible] CAUSE OF DEATH in plain terms, [illegible] may be properly classified. [illegible] of OPERATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETELY DESCRIBED BY [illegible]

S-1235