

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

Do not use this space.

30-172
33

1. PLACE OF DEATH

County..... Shelby
Township..... East River
City..... Shelbina (No.....) St..... Ward.....

Registration District No. 830
Primary Registration District No. 6091

File No.
Registered No.

2. FULL NAME

Hanna Alexander Noel

(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 F 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widow

5A. IF MARRIED, WIDOWED, OR DIVORCED MARRIED OF (OR) WIFE OF Edward P Noel

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 3 1848

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
79 | 10 | 8

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housewife
(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) Kentucky

10. NAME OF FATHER

Jacob Oglesby

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Va.

12. MAIDEN NAME OF MOTHER

Harriet Lamas

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Va.

14.

INFORMANT J. W. Hoil
(Address) Lewis, Mo.

15.

FILED..... 19..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10-11 1928

17. I HEREBY CERTIFY, That I attended deceased from 2-3 to 10-11, 1928, and that I last saw her alive on 10-10, 1928, and that death occurred, on the date stated above, at 11 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cardio-vascular disease

95B
CONTRIBUTORY (SECONDARY) 90B
(duration) 6 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? no. DATE OF.....

WAS THERE AN AUTOPSY? no.

WHAT TEST CONFIRMED DIAGNOSIS? clinical
(Signed) A. M. Wood M. D.
(Address) Shelbina, Mo.

*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 DATE OF BURIAL
Union Grove, Mo. Oct 13 1928

20. UNDERTAKER ADDRESS
Hayes Shelbina,

N. R.—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.

1928

SECRET
CONFIDENTIAL

XX history of records of
statements. Exact statements

USE OF DATA
The following information should be carefully reviewed

**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 Shelby Registration District No. 830 File No. 73
 Township Salt River Primary Registration District No. 6091 Registered No. _____
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

Hanna Alexander Noel
 (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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Wid
(write the word)

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 _____ (duration) yrs. mos. ds.
 (b) General nature of industry, business, or establishment in which employed (or employer) _____ (duration) yrs. mos. ds.
 (c) Name of employer _____

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

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) _____

FILED Nov. 10, 1928 Madge Good REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10-11-1928

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

THE CAUSE OF DEATH WAS AS FOLLOWS:

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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____ DATE OF BURIAL _____

20. UNDERTAKER _____ ADDRESS _____

N. B. Information should be carefully applied. AGE should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

SUPPLEMENTARY

S-35772