

FEB 21 1929

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

Do not use this space.

1069

1. PLACE OF DEATH

County Greene
Township Boone
City Ark. State (No. 5025)

Registration District No. 320
Primary Registration District No. 6443

File No. 1
Registered No. 1
St. 1 Ward

2. FULL NAME Mrs. Harissa Noble

(a) Residence. No. 1 St. 1 Ward. 1
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

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

6A. IN-MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Tom Coble

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 2-27-1872

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
56 11 2

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

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

PARENTS

10. NAME OF FATHER William Tine

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Greene Co Mo.
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Mary Creep

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Tenn.
(STATE OR COUNTRY)

14. INFORMANT Anna Heskett
(Address)

15. FILED 2-1, 1929 Luey Hoy REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb - 29, 1929

17. I HEREBY CERTIFY, That I attended deceased from July, 1928, to Jan 28, 1929 that I last saw her alive on Jan 28, 1929, and that death occurred, on the date stated above, at 1225 1/2

THE CAUSE OF DEATH* WAS AS FOLLOWS:

absorption of food
1.390 (duration) yrs. mos. da.

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

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH?

1 DID AN OPERATION PRECEDE DEATH? Yes DATE OF 1-28-29

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? operative

(Signed) Charles H. McFadden, M.D.

1-29, 1929 (Address) Ark. State, 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

Prospect 1-30-1929

20. UNDERTAKER ADDRESS

J. H. Morris & Lina Miller, Mo.

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.

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RECORDS

AGB should

with non zero

... in plain terms ...

**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 Green Registration District No. 316 File No. 1
 ✓ Township Boone Primary Registration District No. 5435 Registered No. 10
 City (No. St. Ward)

2. FULL NAME Marissa Cable
 (a) Residence. No. St. Ward. (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 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) 2-27-1872

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>56</u>	<u>11</u>	<u>2</u>	

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)

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)

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) JAN 29 1929 19

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Obstruction of bowels
Due to adhesions from
abdominal my some 8 months
ago (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) 118 192 (duration) yrs. mos. da.

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.

14. INFORMANT (Address)

15. FILED 6-10-29 Dr Charles A. O'Neil REGISTRAR

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

20. UNDERTAKER ADDRESS

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW
 should be carefully supplied. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is very important.

6901-5

requested to make every effort to obtain the
dated by check marks, lacking from the death certificate:

Name: _____

Mrs. Narissa Cable

Who died at: _____

Greene Co.

on _____

Jan. 29, 1929.

Residence: No. _____

St. _____

(If nonresident, city or town)

Length of residence in city or

town where death occurred: Years _____

Months _____

Days _____

Sex: _____

Color or race: _____

Single, married, widowed or divorced: _____

Date of birth: _____

Age: Years _____

Months _____

Days _____

Occupation: (a) Trade _____

(b) Industry: _____

Birthplace (State or country) _____

Birthplace of father (State or country) _____

Birthplace of mother (State or country) _____

1892

CAUSE OF DEATH: _____

Obstruction of bowels

*Due to adhesions from a hysterectomy
some 5 months before.*

Contributory: _____

Retrospected uterus with adhesions

*to bowel causing chronic partial obstruction of
bowels*

Where was disease contracted? _____

Did operation precede death? _____

yes

Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

Name of physician: _____

Charles H. McHaffie

Address of physician: _____

Ash Grove, Mo.

(S)-1069