

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

Do not use this space.

19057

27-1079

1. PLACE OF DEATH *Parkville*
 County *Platte* Registration District No. *695*
 Township *Parkville* Primary Registration District No. *4417*
 City *Parkville* (No.) St. Ward)

2. FULL NAME *Harry Clifton Noland*
 (a) Residence. No. *Parkville* 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. *60* mos. *10* ds. *25* How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *male*
 4. COLOR OR RACE *white*
 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Married*

5A. IF MARRIED, WIDOWED, OR DIVORCED *deceased*
 HUSBAND OF (OR) WIFE OF *Ara Noland*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *July 3 1878*

7. AGE *50* YEARS MONTHS *10* DAYS *26*
 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) *Parkville Mo*
 (STATE OR COUNTRY)

10. NAME OF FATHER *Abe Noland*
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Missouri*
 (STATE OR COUNTRY)
 12. MAIDEN NAME OF MOTHER *Elizabeth Noland*
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *Missouri*
 (STATE OR COUNTRY)

14. INFORMANT *Mrs. H. Noland*
 (Address) *Parkville*

15. FILED 19..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *May 28 1929*
 17. I HEREBY CERTIFY, That I attended deceased from *Jan 1* 1929, to *May 28* 1929 that I last saw him alive on *May 27* 1929, and that death occurred, on the date stated above, at *4:25* a. m.

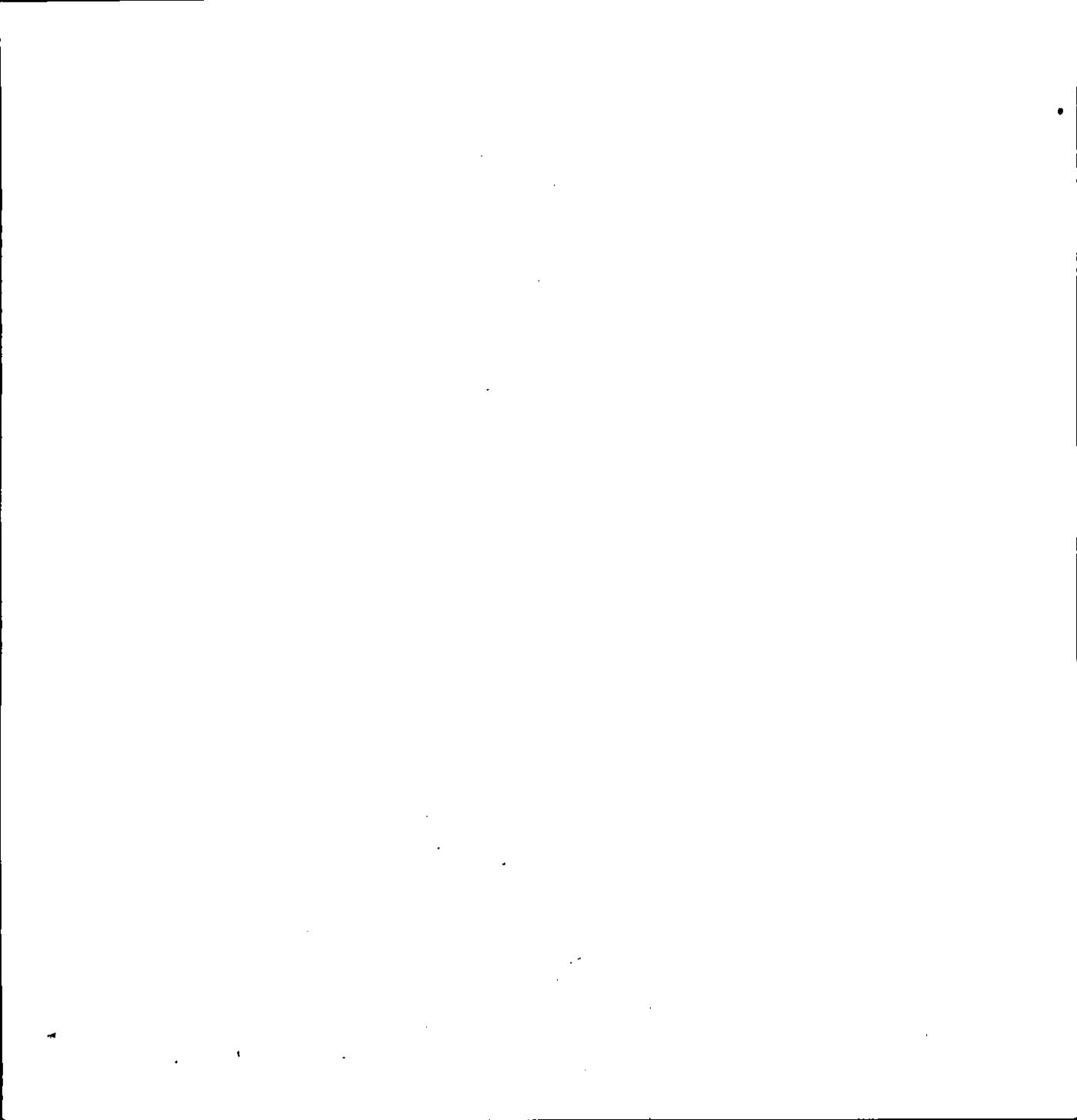
THE CAUSE OF DEATH* WAS AS FOLLOWS:
12:4 P
Heart failure

(duration) yrs. *3* mos. ds.
 CONTRIBUTORY *Cirrhosis Liver*
 (SECONDARY) (duration) yrs. *3* mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 NOT AT PLACE OF DEATH
 DID AN OPERATION PRECEDE DEATH? *No* DATE OF
 WAS THERE AN AUTOPSY? *No*
 WHAT TEST CONFIRMED DIAGNOSIS
 (Signed) *J. M. Anderson* M. D.
 . 19 *Parkville* (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 *Walnut Grove* DATE OF BURIAL *May 30 1929*
 20. UNDERTAKER *Ara Noland* ADDRESS *Parkville*



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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Platte Registration District No. 695 File No.
Township Primary Registration District No. 4417 Registered No.
City Packville (No.) St. Ward)

2. FULL NAME

Harry Clifton Nolan
(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)

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

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

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:

CONTRIBUTORY (SECONDARY)

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

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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