

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

Do not use this space.

1. PLACE OF DEATH

County St. Charles Registration District No. 757 File No. 20410
 Townshp St. Charles Primary Registration District No. 5798 Registered No. 101
 City..... (No.....) St. Ward)

2. FULL NAME

Infant Noelle

(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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 9-1930

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 None
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) St. Charles
 (STATE OR COUNTRY) Mo

10. NAME OF FATHER Arthur Noelle

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) South Dakota

12. MAIDEN NAME OF MOTHER Mable Kline

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) St. Charles Mo

14. INFORMANT Arthur Noelle
 (Address) Rt # 5 St. Charles Mo.

15. FILED 6/10 1930 My S. Blackburn REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 9 1930

17. I HEREBY CERTIFY, That I attended deceased from June 9, 1930, to June 9, 1930, that I last saw him alive on June 9, 1930 and that death occurred, on the date stated above, at St. Charles Mo.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

1608
Cerebral Hemorrhage
do do
 (duration) yrs. mos. ds.

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

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

DID AN OPERATION PRECEDE DEATH? DATE OF

WHAT TEST CONFIRMED DIAGNOSIS Signs & Symptoms
 (Signed) A. H. St. Charles, M. D.

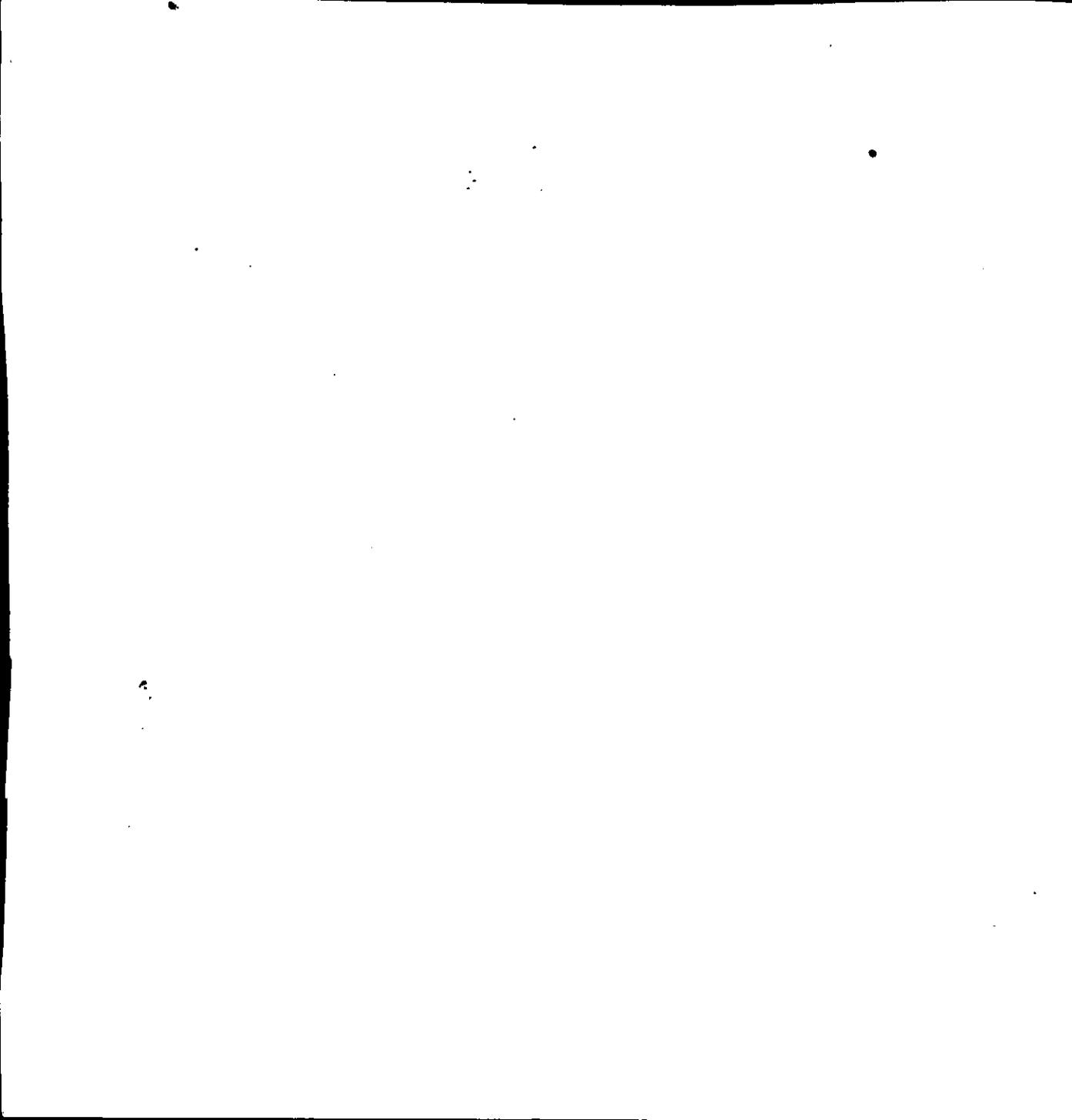
(Address) St. Charles Mo.

*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 St. Charles Burial Home DATE OF BURIAL June 10 1930

20. UNDERTAKER W. H. McMillan ADDRESS 800 W. 11th

PARENTS



**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 St Charles Registration District No. 757 File No.
 Township Primary Registration District No. 5998 Registered No.
 City (No.) St. Ward)

2. FULL NAME Infant Roelle
 (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 7 **4. COLOR OR RACE** W **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** S
(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
 (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 6/10/30 J. G. Bloebaum
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 9 1930

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:
Cerebral hemorrhage

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

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

DID AN OPERATION PRECEDE DEATH? 16/10 DATE OF

WAS THERE AN AUTOPSY? 16/10

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
 19

20. UNDERTAKER ADDRESS

SUPPLEMENTARY

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

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