

WRITE PLAINLY, WITH UNFADING INK---THIS IS A 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.

NOV 1939

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

35687
Do not use this space.

1. PLACE OF DEATH

(a) County Cape Registration District No. 125
 (b) Township Cape Girardeau Primary Registration District No. 309 Registered No. 346
 (c) City Cape Girardeau (d) Street No. St Francis Hosp. St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. _____ St. Joseph, Mo.
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct. 8, 1865

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hra. ormin.
74 0 0

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. House Keeper
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Jackson Mo

FATHER 13. NAME Isaac M. Noland

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Keosauqua Iowa

MOTHER 15. MAIDEN NAME Sophia Richards

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Keosauqua Iowa

17. INFORMANT (ADDRESS) Harry Adams, Acton, Ill.

18. BURIAL, CREMATION, OR REMOVAL PLACE Highway Cem. Illinois, Mo. DATE 10/11/39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) B. Splinter, Acton, Ill. Illinois, Mo.

20. FILED 10-6-39 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10-8-39 1939

22. I HEREBY CERTIFY, That I attended deceased from 9-28-39 to 10-8-39

I last saw him alive on 10-7-39 Death is said to have occurred on the date stated above, at 8:30 m.

The principal cause of death and related causes of importance were as follows:

Carcinoma of stomach
46

Other contributory causes of importance:
Survival shock of intestinal obstruction

Name of operation Leporectomy Date of 10-6-39

What test confirmed diagnosis? r Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____ Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____ If so, specify _____

(Signed) T. Washburn, M. D. (Address) Cape Girardeau

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.

working under my personal supervision.

Signed *Walter B. Dwyer*

Licensed Embalmer No. *3242*

P. O. Address *Chaffee Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.