

FILED APR 28 1941

Registration District No. _____

Primary Registration District No. 1

Registrar's No. 101

1. PLACE OF DEATH:

(a) County Missouri Adair Co
(b) City or town Middle Grove, Missouri
(c) Name of hospital or institution: Middle Grove Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community 7 years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Howard 45
(c) City or town Higbee (If outside city or town limits, write "RURAL") 0
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? 1 years.

3. (a) PRINT FULL NAME Robert Sylvester NOEL

3. (b) If veteran, name war none 3. (c) Social Security No. none

4. Sex M 0 5. Color or race White 6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife GORA NOEL 6. (c) Age of husband or wife if alive 66 years
7. Birth date of deceased Sept. 13 1872
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
68 1942 3 29 7 hr. 40 AM min.

9. Birthplace Marion Co. (Middle Grove) 1
(City, town, or county) (State or foreign country)

10. Usual occupation FARMER

11. Industry or business _____

MOTHER FATHER { 12. Name LeRoy Noel
13. Birthplace Kentucky 1
(City, town, or county) (State or foreign country)
14. Maiden name Bill (given name unknown)
15. Birthplace Kentucky 1
(City, town, or county) (State or foreign country)

16. (a) Informant Mr Lib Noel
(b) Address Hannable Mo

17. (a) Higbee (b) Date thereof 3 30 41
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation New Hope

18. (a) Signature of funeral director W. E. Seaborn
(b) Address Higbee Mo

19. (a) March 29 1941 (b) Spencer I. Freeman
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 29
year 1941 hour 7 minute 50 A M.

21. I hereby certify that I attended the deceased from March 5
_____, 1941, to March 29, 1941;
that I last saw him alive on March 29, 1941;
and that death occurred on the date and hour stated above.

Immediate cause of death Cancer Duration _____

Due to Prostatic obstruction

Due to _____

Other conditions (include pregnancy within 3 months of death) _____

Major findings: Prostatotomy PHYSICIAN _____
Of operations Adeno-carcinoma
Of autopsy _____

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Spencer I. Freeman (M. D. or other) 3
Address Higbee Mo Date signed 3/29/41

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

5-5

RECEIVED

District Health Officer No. 10

District File Number 4-41-819

Date Filed APR 14 1941

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 L. L. Felton

Licensed Embalmer No. 1399

P. O. Address Highes m

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.

No. 2
4-41
17-39
X26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 9887

Registration District No. 1 Primary Registration District No. 1 Registrar's No. _____

1. PLACE OF DEATH:
(a) County Adair
(b) City or town Kirksville Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Robert Sylvester Noel
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Mar day 29
year 1941 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____;
that he last saw me alive on _____ 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death Uremia Duration _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced W
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased: Sept 13 1872
(Month) (Day) (Year)
8. AGE: Years 69 Months 3 Days 29 If less than one day hr. _____ min. _____

Due to _____ 5/8
Due to _____

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)
10. Usual occupation _____
11. Industry or business _____
12. Name _____
13. Birthplace _____ (City, town, or county) _____ (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

Other conditions Prostatectomy
(Include pregnancy within 3 months of death)
Major findings: Adeno Carcinoma PHYSICIAN _____
Of operations: of prostate Underline the cause to which death should be charged statistically.
Of autopsy _____

16. (a) Informant _____ (b) Address _____
17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal) _____
(c) Place: burial or cremation _____
18. (a) Signature of funeral director _____
(b) Address _____
19. (a) _____ (b) _____
(Date of local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

Laughlin (Do) Kirksville Mo (Licensed Embalmer's Statement on Reverse Side) filed 2nd time 6-8-41

S-9887 1941

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.....

Licensed Embalmer No.....

P. O. Address.....

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, fact should be so stated above.

2
-41
-39
K28390

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 9887

Registration District No. 1

Primary Registration District No. 1

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Adair

(b) City or town Kennett
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME Robert Sylvester Noel

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w

6. (a) Single, widowed, married, divorced m

6. (c) Age of husband or wife _____ years _____ months _____ days _____ hr. _____ min.

7. Birth date of deceased Sept 13 1872
(Month) (Day) (Year)

8. AGE: Years 68 69 Months 36 Days 29
If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) June 9/41 (b) Spencer L. Freeman
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____ (If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 29
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____;
that I last saw him _____ alive on _____ 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) _____

(c) Means of injury _____

23. Signature Earl Loughtin Jr (M.D. or other) _____

Address Kennett mo Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

S-9887 1941

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.....

Licensed Embalmer No.....

P. O. Address.....

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

If this body is not embalmed, fact should be so stated above.