

APR 9 1941 217  
Registration District No.

Primary Registration District No. 5611

State File No.

Registrar's No. 2

1. PLACE OF DEATH:  
(a) County Laclede  
(b) City or town Haylesgreen, Mo.  
(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 1 (Specify whether  
In this community years, months or days)

3. (a) PRINT FULL NAME NOBLE DOUGAN

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

4. Sex male 5. Color of race white 6. (a) Single, widowed, married, divorced married

6. Name of husband or wife Beattie Dougan 6. (c) Age of husband or wife if alive 32 years

7. Birth date of deceased Sept 22 1900  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>40</u>	<u>6</u>	<u>9</u>	hr. min.

9. Birthplace Laclede Co Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business

12. Name William Dougan

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

14. Maiden name Medie Walton

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

16. (a) Informant George Dougan

(b) Address Haylesgreen

17. (a) Burial (b) Date thereof 3-16/41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Haylesgreen

18. (a) Signature of funeral director Ricklund

(b) Address Ricklund  
(c) Date received local registrar 3-15-41 (d) L. E. Carlson (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Laclede  
(c) City or town Haylesgreen Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. 0 (If rural, give location)  
(e) If foreign born, how long in U. S. A? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 11th  
year 1941 hour 3 minute 40pm

21. I hereby certify that I attended the deceased from 3-8, 1941 to 3-11, 1941  
that I last saw him alive on 3-10, 1941  
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia  
Due to bilateral

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations  
Of autopsy NO

Duration  
PHYSICIAN  
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) no

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

23. Signature Ricklund (D. or other)  
Address Ricklund, Mo. Date signed 3/14/41

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

MOTHER FATHER

109

RECEIVED

District Health Officer No. 7,  
District File Number 4-41-596  
Date Filed 4-7-41

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

*R B Jepple*  
Licensed Embalmer No. 3198  
P. O. Address *Richland 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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 11144

Registration District No. 277

Primary Registration District No. 5611

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

- (a) County Laclede  
 (b) City or town South 7th  
 (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 Noble Douglas

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. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ year

7. Birth date of deceased: \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

8. AGE: Years 40 Months 6 Days 9 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 \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (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 11  
 year 1947 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
 that I last saw h \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
 and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia Duration \_\_\_\_\_  
(relaxed)

Due to Lobar

Due to Flu and Cold

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_ PHYSICIAN \_\_\_\_\_  
 Of operations ZZW

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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

MOTHER FATHER

WALIE PLAINLI—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1941

S-11144