

No. 2
4-13-
-17-29

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

19547

State File No.

489

Registration District No. 85

Primary Registration District No. 1001

Registrar's No.

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution
17 th Garfield /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community 53 Years 10 Mo. 20 Days
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Buchanan
(c) City or town St. Joseph
(If outside city or town limits, write "RURAL")
(d) Street No. 3151 S. 15th.
(If rural, give location)
(e) If foreign born, how long in U. S. A. 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 2nd
year 1941 hour 5 minute 12 P. M.

21. I hereby certify that I attended the deceased from
May 2, 1941, 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 Compressed skull fractures of the frontal and occipital bones.
Due to Cerebral hemorrhage.
Due to _____

Duration

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

Major findings:
Of operations _____

Of autopsy no

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) Accident 122
(b) Date of occurrence May 2 - 1941
(c) Where did injury occur? Ashbrook Ave. Mo.
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Public Street - Railroad Crossing
(Specify type of accident) (e) Means of injury 2 coroner
While at work? no

23. Signature H. F. Mundy (M. D. or other) 85
Address 404 No. 3d, St. Date signed 5/4/41

3. (a) PRINT FULL NAME LAFAYETTE F. NOLAND

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

4. Sex male 0
5. Color or race white
6. (a) Single, widowed, married, divorced Divorced

6. (b) Name of husband or wife Ethel Noland
6. (c) Age of husband or wife if alive ? 49 years

7. Birth date of deceased June 12th, 1887
(Month) (Day) (Year)

8. AGE: Years 53 Months 10 Days 20
If less than one day hr. min.

9. Birthplace Holt County Mo. 0
(City, town, or county) (State or foreign country)

10. Usual occupation Fireman Goetz Brewery

11. Industry or business retired

12. Name Charles Noland

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

14. Maiden name Lillie Holland

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

16. (a) Informant Mrs. Marie Boleski

(b) Address 3151 S. 15th. St. Joseph, Mo.

17. (a) Burial (b) Date thereof 5--5--41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ashland Cemetery

18. (a) Signature of funeral director FLEEMAN & SON INC.

(b) Address St. Joseph, Mo.

19. (a) 5-5-1941 (b) H. J. Mattheus
(Date received local registrar) (Registrar's signature)

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

11
1
7

11
1
7

169
30

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, me
....., Registered Apprentice No.
working under my personal supervision.

Signed Geo E Daniel

Licensed Embalmer No. 3300

P. O. Address 8x Joseph W

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.

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

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St. Joseph
(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 Lafayette F. Noland

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 Div

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

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

8. AGE: Years 53 Months 10 Days 20 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) _____ (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 May day 2
year 1941 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: Compressed skull fractures of the frontal and occipital
Due to Gunshot

Due to Cerebral Hemorrhage

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

Major findings: 104'
Of operations: _____
Of autopsy: _____

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) acc

(b) Date of occurrence May 2 1941

(c) Where did injury occur: St. Joseph mo
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Public ST R.R. Crossing
(Specify type of place)
While at work Redistricting Meeting

23. Signature H.F. Mundy Locomotive
(M. D. or other)
Address _____ Date signed _____

SUPPLEMENTARY

19547