

No. 2  
-2-43  
5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **41195**  
Registrar's No. **5481**

Registration District No. **149**

Primary Registration District No. **1002**

1. PLACE OF DEATH:  
(a) County **Jackson**  
(b) City or town **Kansas City**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**K. C. General Hospital No. 1**  
(If not in hospital or institution, write street number and location)  
(d) Length of stay: In hospital or institution **2 days**  
(Specify whether  
In this community **3 years**  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Missouri** (b) County **Jackson**  
(c) City or town **Kansas City**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **627 Woodland**  
(If rural, give location)  
(e) Citizen of foreign country? **No** (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **Jackie Noel (Robert)**  
3. (b) If veteran, name war **No**  
3. (c) Social Security No. **497-14-6206**

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **December** day **19**  
year **1943** hour **9** minute **25 A.M.**

4. Sex **Male** 5. Color or race **White**  
6. (a) Single, widowed, married, divorced **Single**  
6. (b) Name of husband or wife \_\_\_\_\_  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased **Dec. 25 1924**  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **December 17 1943** to **December 19 1943**  
that I last saw him alive on **December 19 1943**  
and that death occurred on the date and hour stated above.  
Immediate cause of death **meningococcus meningitis**  
Duration \_\_\_\_\_

8. AGE: Years Months Days If less than one day  
**18 11 24** hr. min.

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

9. Birthplace **Cabool, Missouri**  
(City, town, or county) (State or foreign country)

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

10. Usual occupation **Laborer**

11. Industry or business **Continental Can Co**

12. Name **Pernie E. Noel**

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

14. Maiden name **Mattie Baney**

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

16. (a) Informant **Mrs. Sidney Noel**

(b) Address **627 Woodland**

17. (a) **Burial** (b) Date thereof **Dec. 23, 1943**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Memorial Park Cemetery**

18. (a) Signature of funeral director **C. H. Blackman & Son,**  
(b) Address **Kansas City, Mo.**

19. (a) **12-23-43** (b) **D. E. Brown**  
(Date received local registrar) (Registrar's signature)

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) \_\_\_\_\_  
(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? \_\_\_\_\_

23. Signature **Drury R. Shaw** (M. D. or other) \_\_\_\_\_  
Address **Med. Dir. Gen'l Hosp.** Date signed **12-20-43**

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

MOTHER FATHER

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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 B. H. Blackman

Licensed Embalmer No. 2244

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.**