No. 2
9-4-41
17-39
X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 14 1944

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

3127

State File No.

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 1

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution: 706 N. Spring St.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community About 45 yrs.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson. 48 4

(c) City or town Independence. 4
(If outside city or town limits, write "RURAL")

(d) Street No. 706 N. Spring St.
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Elijah Noland.

3. (b) If veteran, name war —

3. (c) Social Security No. None

4. Sex Female 5. Color or race Negro 6. (a) Single, widowed, married, divorced Married 1

6. (b) Name of husband or wife David Noland.

6. (c) Age of husband or wife if alive 93 years

7. Birth date of deceased Dec. (Month) 25, (Day) 1869. (Year)

8. AGE: Years 74-yrs. Months — Days 4 da. If less than one day hr. min.

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

10. Usual occupation House Wife

11. Industry or business

FATHER
12. Name Willie McCary
13. Birthplace Unknown (City, town, or county) Unknown. (State or foreign country)

MOTHER
14. Maiden name Sallie Cosen
15. Birthplace Glasco, (City, town, or county) Mo. 0 (State or foreign country)

16. (a) Informant Mattie Vaughn.
(b) Address 706 N. Spring St.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 3, 1943 (Month) (Day) (Year)
(c) Place: burial or cremation Woodlawn - Cem.

18. (a) Signature of funeral director C. E. Davis
(b) Address 312 E. Lexington St. Indep., Mo.

19. (a) 10-6-1944 (Date received local registrar) (b) James W. Ross (Registrar's signature)

1163

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 29, year '43 hour 1 minute a. M.

21. I hereby certify that I attended the deceased from 11-15-43, 19, to 12-28, 1943 that I last saw her alive on 12-28, 1943 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Influenza	6 wks
Due to	
Due to	
Other conditions General debility (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy 33a

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? (Specify type of place)

While at work? (e) Means of injury 10

23. Signature W. A. Laurel (M. D. or other)
Address 119 E. Farmer Date signed 1-4-44

(Licensed Embalmer's Statement on Reverse Side)

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 J Harris Sr.

Licensed Embalmer No. 3388

P. O. Address Ft. Q. Mo.

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

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

No. 2B
I—5-43
X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 3127

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 1

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Independence
(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 Elijah Noland
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex F
5. Color or race B
6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Dec (Month) 25 (Day) (Year)
8. AGE: Years 74 Months Days If less than one day hr. min.
9. Birthplace (City, town, or county) Mo. (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) 3/9/44 (Date received local registrar) (b) James W. Ross (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec Day 9 year 1943 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 — Duration
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
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)
(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? (Specify type of place)
While at work? (e) Means of injury

23. Signature W. H. Lawrie (M. D. ~~or other~~) MD
Address 119 E. Farmer Indp. Mo. Date signed 1-4-44

SUPPLEMENTARY