No. 2
-2-43
17-39
X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 6 1944

Registration District No. 24

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3089

State File No. 7665

Registrar's No.

1. PLACE OF DEATH:
(a) County Linn
(b) City or town Marceline 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 years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Linn 58
(c) City or town Marceline
(If outside city or town limits, write "RURAL")
(d) Street No. 217 E Chicago
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME OLEY GREENE NOAH
3. (b) If veteran, name war World War #1
3. (c) Social Security No. 486-12-9126
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Zelma Noah
6. (c) Age of husband or wife if alive 43 years
7. Birth date of deceased June 18 1891 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
52	6	26	hr. min.

9. Birthplace Macon Co. Mo (City, town, or county) (State or foreign country)
10. Usual occupation Laborer
11. Industry or business
FATHER 12. Name James Noah
13. Birthplace Missouri (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name Lee Ann Craig
15. Birthplace Missouri (City, town, or county) (State or foreign country)
16. (a) Informant Mrs Zelma Noah
(b) Address Marceline Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-18-44 (Month) (Day) (Year)
(c) Place: burial or cremation Mt Olivet
18. (a) Signature of funeral director James McLaughlin
(b) Address Marceline Mo
19. (a) 2/16/44 (Date received local registrar) (b) P. L. Petrick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 14 year 1944 hour 10 minute P.M.
21. I hereby certify that I attended the deceased from June 27 1941 to Feby 14 1944 that I last saw him alive on Feby 8 1944 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Failure	
Due to Aortic regurgitation	4 yrs
Due to Chronic myocarditis	4 yrs
Other conditions (Include pregnancy within 3 months of death) Hypertension	4 yrs

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 P. L. Petrick (M. D. or other)
Address Marceline Mo Date signed 2-16-44

1350 (Licensed Embalmer's Statement on Reverse Side)

MAR 9 1964

MAR 6 194

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.....Dale Bunch

Licensed Embalmer No.....4088

P. O. Address Marceline Mo

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

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

No. 2B
1—5-43
I 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

MAR 8

State File No. ____

Registration District No. 285 Primary Registration District No. 3029 Registrar's No. ____

1. PLACE OF DEATH:
(a) County Linn
(b) City or town Marceline
(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 years, months or days)
In this community ____

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 Alex Green Noah
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 ____ years
7. Birth date of deceased June (Month) 18 (Day) 1894 (Year)
8. AGE: Years 52 Months 6 Days 26 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) 3/16/44 (Date received local registrar) (b) P. L. Patrick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 24 year 1944 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 Acute heart failure — Duration ____
Due to aortic regurgitation — 1 yr.
Due to aneurysm of aorta
Other conditions Hypertension
(Include pregnancy within 3 months of death)
Major findings: Of operations No syphilis
Of autopsy 96

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 P. L. Patrick (M. D. or other) 3/16/44
Address ____ Date signed ____

SUPPLEMENTARY

76605