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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

30496

**FILED** OCT 4 1945 **STANDARD CERTIFICATE OF DEATH**

State File No. \_\_\_\_\_

Registration District No. 116

Primary Registration District No. 3020 45434

Registrar's No. 86

1. PLACE OF DEATH:  
 (a) County Franklin  
 (b) City or town Bever, Washington  
 (c) Name of hospital or institution: St. Francis Hospital  
 (d) Length of stay: In hospital or institution 2 day  
 In this community \_\_\_\_\_  
 years, months or days

2. USUAL RESIDENCE OF DECEASED:  
 (a) State MO (b) County Franklin  
 (c) City or town Rural  
 (d) Street No. 1 1/2 South of Berger  
 (e) Citizen of foreign country? no (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME JANE GENE NOEDEL

3. (b) If veteran, name war no 3. (c) Social Security No. no

4. Sex MALE 5. Color or race W 6. (a) Single, widowed, married, divorced single

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

7. Birth date of deceased AVC 31 1945  
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
 \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Washington MO  
 (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name Eugene Noedel

13. Birthplace Berger MO  
 (City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Rohlfing MO  
 (City, town, or county) (State or foreign country)

15. Birthplace Berger MO  
 (City, town, or county) (State or foreign country)

16. (a) Informant Eugene Noedel  
 (b) Address Berger R75 #1 MO

17. (a) Burial (b) Date thereof 9-3-45  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Johns Roman Berger MO

18. (a) Signature of funeral director Harold Blumack  
 (b) Address Berger MO  
 19. (a) Sept 1 1945 (b) [Signature]  
 (Date received local register) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 1 year 1945 hour 9:30 minute A M.

21. I hereby certify that I attended the deceased from Aug 31, 1945 to Sept 1, 1945 that I last saw him alive on Sept 1, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death prematurity (7 Mo gestation)

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

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

Of autopsy \_\_\_\_\_

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) Manner of injury \_\_\_\_\_

23. Signature Frank J. [Signature] (M. D. or other) MO

Address 311 1/2 W. Washington MO Date signed 9-1-45

Duration  
 PHYSICIAN  
 Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

1449

(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, *only*, *this body was not embalmed*

..... Registered Apprentice No. *AT*  
working under my personal supervision.

Signed *Herbert Blumer*

Licensed Embalmer No. *2047*

P. O. Address *Page 140*

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.

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. 30 x 96Registration District No. 116Primary Registration District No. 3020Registrar's No. 86

## 1. PLACE OF DEATH:

- (a) County Franklin  
 (b) City or town Washington  
 (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 Dale B. Noel

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 s

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

7. Birth date of deceased
- aug 3
- (Month) (Day) (Year)

8. AGE: ( Years Months Days ) (If less than one day, hr. min.) mo

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 \_\_\_\_\_ (State or foreign country)

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)
- 10/17/45
- (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 \_\_\_\_\_ Year
- 1945
- hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 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 \_\_\_\_\_

## 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) (c) Means of injury \_\_\_\_\_

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

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

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

MOTHER FATHER

SUPPLEMENTARY

## PHYSICIAN

Underline the cause to which death should be charged statistically.

