

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF HEALTH CARES
THE STATE BOARD OF HEALTH OF MISSOURI
FILED MAR 15 1946 **STANDARD CERTIFICATE OF DEATH**

State File No. **5366**

Registration District No. **183** Primary Registration District No. **4285** Registrar's No. **28**

1. PLACE OF DEATH:
(a) County **Harrison**
(b) City or town **Gilman City**
(c) Name of hospital or institution: **1**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institutions **all of life** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo** (b) County **Harrison**
(c) City or town **Gilman City** (If outside city or town limits, write "RURAL")
(d) Street No. **3** (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME **Effie Mae Noll**
3. (b) If veteran name war **L**
3. (c) Social Security No. **L**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Feb** day **16** year **1946** hour **5** minute **30 A** M.
21. I hereby certify that I attended the deceased from **Feb 8** 1946 to **Feb 13** 1946 that I last saw him alive on **Feb 13** 1946 and that death occurred on the date and hour stated above.

4. Sex **Female** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **married**
6. (b) Name of husband or wife **W. J. Noll** 6. (c) Age of husband **79** years alive **79** years
7. Birth date of deceased **May 2 1866** (Month) (Day) (Year)

Immediate cause of death **Cerebral Hemorrhage**
Due to **arteriosclerosis** **8 years**
Due to

8. AGE: Years **79** Months **9** Days **14** If less than one day hr. min.
9. Birthplace **Harrison Co. Mo.** (City, town, or county) (State or foreign country)
10. Usual occupation **Housewife**

Other conditions **Chronic Myocarditis** **5 yrs**
(Include pregnancy within 3 months of death)
Major findings: **93d**
Of operations **L**
Of autopsy **L**

MOTHER FATHER
11. Industry or business
12. Name **Alphus A. Williams**
13. Birthplace **New York State**
14. Maiden name **Charlotte Sherman**
15. Birthplace **New York State**
16. (a) Informant **ms Allie Cole**
(b) Address **Gilman City Mo**
17. (a) **Burial** (b) Date thereof **2-18-1946** (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director **Joe E. Wheeler**
(b) Address **Bethany Mo**
19. (a) **Feb-25-46** (b) **John Harris** (Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) **L**
(b) Date of occurrence **L**
(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? **L**
While at work? **L** (Specify type of place) (e) Means of injury **L**
23. Signature **W. F. Boyles** (M. D. or other) **1**
Address **Bethany Mo** Date signed **2/20/46**

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

DISTRICT HEALTH OFFICE
Cameron, Mo.

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.....

Joe E. Wheeler

Licensed Embalmer No. 3512

P. O. Address Bethany Mo.

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.