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17-39  
X35697

**FILED** MAR 4 8 1946

Registration District No. \_\_\_\_\_  
Primary Registration District No. **4233**

Registrar's No. **1**

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

**1. PLACE OF DEATH:**  
 (a) County Iron  
 (b) City or town Arcadia  
(If outside city or town limits, write "RURAL" and name of township)  
 (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 institution \_\_\_\_\_  
(Specify whether years, months or days)  
 In this community seven years

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State Missouri (b) County Iron **47**  
 (c) City or town Arcadia **0**  
(If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_  
(If rural, give location)  
 (e) Citizen of foreign country? no **0**  
(Yes or No)  
 If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** Ada Orena Noves  
 3. (b) If veteran, name war no  
 3. (c) Social Security No. none  
 4. Sex female 5. Color or race white  
 6. (a) Single, widowed, married, divorced, married  
 6. (b) Name of husband or wife Frank Noves  
 6. (c) Age of husband or wife if alive 80 years  
 7. Birth date of deceased June 22 1867  
(Month) (Day) (Year)

**MEDICAL CERTIFICATION**  
 20. DATE OF DEATH: Month Feb. day 24  
 year 1946 hour 11 minute 00 A.M.  
 21. I hereby certify that I attended the deceased from Feb. 1  
1946 to Feb. 24 1946  
 that I last saw her alive on Feb. 24, 1946  
 and that death occurred on the date and hour stated above.

**8. AGE:** Years 78 Months 8 Days 2  
If less than one day hr. \_\_\_\_\_ min.  
 9. Birthplace Manchester Iowa  
(City, town, or county) (State or foreign country)  
 10. Usual occupation at home  
 11. Industry or business \_\_\_\_\_  
**MOTHER FATHER**  
 12. Name Curtis C. Peer  
 13. Birthplace unknown **4**  
(City, town, or county) (State or foreign country)  
 14. Maiden name unknown  
 15. Birthplace Unknown **4**  
(City, town, or county) (State or foreign country)  
 16. (a) Informant Rav Noves  
 (b) Address Ironton Mo.  
 17. (a) burial (b) Date thereof 2-27-46  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Ironton Mo.  
 18. (a) Signature of funeral director Norman White & Sons  
 (b) Address 2 White Ironton Mo.  
 19. (a) Feb 28 - 46 (b) Mrs. A. Jones  
(Date received local registrar) (Registrar's signature)

Immediate cause of death Pneumonia  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions Cerebral Hemorrhage  
(Include pregnancy within 3 months of death)  
 Major findings:  
 Of operations none  
 Of autopsy none  
**ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED**  
**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 \_\_\_\_\_ (c) Means of injury \_\_\_\_\_  
 23. Signature [Signature] (M. D. or other) MD  
 Address [Address] Date signed 2-26-46

RECEIVED

District Health Officer No. 4  
District File Number 346-1826  
Date Filed 3-8-46

**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 Quincy J. White

Licensed Embalmer No. 3012

P. O. Address Easton, N.J.

**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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. Mar  
Registrar's No. 1

Registration District No. 144

Primary Registration District No. 7233

1. PLACE OF DEATH:

(a) County Jean  
(b) City or town Arcaadia  
(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) PRENT FULL NAME Ada O. Nayer

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced \_\_\_\_\_

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

7. Birth date of deceased June 22 (Month) (Day) (Year)

8. AGE: Years 78 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

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

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

MOTHER FATHER { 12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (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 July Day 24  
year 1946 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 \_\_\_\_\_

Due to Bronchitis

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) Means of injury \_\_\_\_\_

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

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

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY INFORMATION REQUESTED

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

1946

5468