

FILED NOV 25 1946

Primary Registration District No. **3000**

Registrar's No. **403**

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

1. PLACE OF DEATH:

(a) County **ADAIR**
(b) City or town **IRKSVILLE**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **LAUGHAN HOSP.**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1 Day**
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **ILLINOIS** (b) County **MARION**
(c) City or town **CENTRALIA**
(If outside city or town limits, write "RURAL")
(d) Street No. **516 W. 3rd ST.**
(If rural, give location)
(e) Citizen of foreign country? **NO** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **WILLIAM J. NOLL**

3. (b) If veteran, name war _____ 3. (c) Social Security No. **332-48-2966**

4. Sex **male** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **single**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **August 16 1946**
(Month) (Day) (Year)

8. AGE: Years **62** Months **2** Days **23** If less than one day hr. min.

9. Birthplace **Centralia Illinois**
(City, town or county) (State or foreign country)

10. Usual occupation **Night Watchman**

11. Industry or business _____

12. Name **George Noll** **4**

13. Birthplace **Sprangdenburg Germany**
(City, town or county) (State or foreign country)

14. Maiden name **Katherine Claus**

15. Birthplace **Sprangdenburg Germany**
(City, town or county) (State or foreign country)

16. (a) Informant **A. J. Woods**
(b) Address **Irksville, Mo.**

17. (a) **Burial** (b) Date thereof **11-9-46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Centralia Illinois**

18. (a) Signature of funeral director **Salbreath Funeral Home**
(b) Address **Centralia Illinois**

19. (a) **11-9-46** (b) **Kate Lambert**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov.** day **ninth**
year **1946** hour **4:20** minute **A.M.**

21. I hereby certify that I attended the deceased from **Nov 8th**, 1946 to **Nov. 9**, 1946
that I last saw him alive on **Nov. 9**, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death **Pulmonary edema**
Due to **Cancer of esophagus**

Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy **none 46A**

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)
Means of injury _____
23. Signature **A. J. Woods** (M. D. or other) **D.**
Address **Irksville Mo** Date signed **11-9-46**

Duration
1946
1946
PHYSICIAN
Underline the cause to which death should be charged statistically.

RECEIVED
District Health Officer No. 10
District File Number...
Date Filed NOV-22 1946

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 W. C. Summers
Licensed Embalmer No. 2159
P. O. Address Richsville 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.