

Registration District No. 172

Primary Registration District No. 6-626

1. PLACE OF DEATH:

(a) County LAWRENCE
(b) City or town ASH GROVE R.T.D.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Byank, T.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1
In this community 5 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Walter O. Nothapel
3. (b) If veteran, name war..... 3. (c) Social Security No. 40

4. Sex Male 5. Color or race W.
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife LEOLA NOTHAPEL 6. (c) Age of husband or wife if alive 46 years
7. Birth date of deceased 2 8 96
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
51 5 10 hr. min.

9. Birthplace Cook Ned (City, town, or county) (State or foreign country)

10. Usual occupation farmer

11. Industry or business

MOTHER FATHER
12. Name Charles Nothapel 4
13. Birthplace Berlin Germany (City, town, or county) (State or foreign country)
14. Maiden name unknown
15. Birthplace unknown (City, town, or county) (State or foreign country)

16. (a) Informant Charles Nothapel

(b) Address Ash Grove R.T.D.

17. (a) Burial (b) Date thereof 7 15 47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Johns Chapel

18. (a) Signature of funeral director Morris-Leiman

(b) Address Ash Grove Mo

19. (a) 7-21-47 (b) W.S. Buehney
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County LAWRENCE
(c) City or town ASH GROVE R.T.D.
(If outside city or town limits, write "RURAL")
(d) Street No. Byank (If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 19
year 1947 hour 1 minute P M.

21. I hereby certify that I attended the deceased from 7-11 1947 to 7-12 1947
that I last saw him alive on 7-12-47 and that death occurred on the date and hour stated above.

Immediate cause of death Toxemia and Dehydration Duration 4 wks.

Due to Massive abdominal Malignancy 5-7 yrs.

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

Major findings: Malignancy of abdominal organs
Of operations abdominal organs
Of autopsy.....
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?.....

While at work?..... (Specify type of place) (c) Means of injury.....

23. Signature James F. Matz (M. D. or other) Mo.
Address Ash Grove, Mo Date signed 7/14/47

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

FEB 9 1948

RECEIVED

District Health Officer No. 63

District File Number 847-810

Date Filed AUG 12 1947

AUG 14 1949

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 Maude D. Morris
Licensed Embalmer No. 2065
P. O. Address Ash Grove 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Aug
Registrar's No. 28

Registration District No. 176 Primary Registration District No. 5656

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

1. PLACE OF DEATH:

(a) County Lawrence
(b) City or town Rural
(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 Walter O. Nothholz

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

4. Sex M 5. Color of race W 6. (a) Single, widowed, married, divorced MC

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

7. Birth date of deceased 2nd (Month) 1947 (Year)

8. AGE: 51 Years 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)
(Burial, cremation, or removal) _____
(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 _____ Day _____
year 1947 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;
that I last saw _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to Primary SITE - Pylorus of Stomach

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 Thomas F. Metz (M. D. or other) HO
Address Oshtemo, Mo Date signed 8/16/47

SUPPLEMENTARY

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

S-24705

4 - 1/2" - 3710 - 1/2" - 1/2"

20
1/2"