

No. 2
1/47
17-39

National Office of Vital Statistics
FILED SEP 29 1947

Registration District No.

Primary Registration District No. 3033

Registrar's No.

1. PLACE OF DEATH:

(a) County Laclede
(b) City or town Lebanon
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Wallace Memorial Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 100 days
(Specify whether years, months or days) 3 1/2 months

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Laclede
(c) City or town Lebanon
(If outside city or town limits, write "RURAL")
(d) Street No. 33 Greenwood
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Murdo M. Donald DeNoon

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

4. Sex m race w 5. Color or race w
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife unknown 6. (c) Age of husband or wife if alive years
7. Birth date of deceased Sept 29 1864
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
82 11 2 hr. min.

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

10. Usual occupation American Brake Corp Supt. Shipping Dept.

11. Industry or business: Alexander Denoon & Co

12. Name Alexander Denoon & Co

13. Birthplace Scotland (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 A. H. Denoon
(b) Address 33 Greenwood Lebanon Mo

17. (a) Burial (b) Date thereof 9-5-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation City Cemetery Lebanon

18. (a) Signature of funeral director W. F. Holman
(b) Address Lebanon Mo
19. (a) Sept 20 1947 (b) Dr. Frankburg
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 2
year 1947 hour 5 minute 45 P. M.

21. I hereby certify that I attended the deceased from 8-5-47
to Sept 2 1947
that I last saw him alive on Sept 2 1947
and that death occurred on the date and hour stated above.
Duration

Immediate cause of death: Coronary Insufficiency
arterial pattern.

Due to

Due to

Other conditions: Fractured Hip
(Include pregnancy within 3 months of death) May 1947

Major findings: Of operations
Of autopsy 186A

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 Paul Jenkins (M. D. or other) MD
Address Lebanon Mo Date signed 9/27/47

WRITE PLAINLY—USING UNEADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

PHYSICIAN
I certify that the cause of death should be charged statistically.

ADDITIONAL SUPPLEMENT

Received 9/25/47
Laclede County Health Unit
File No. 9-47-157
Date Filed 9/27/47

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 James W. Wair, Registered Apprentice No. 98, working under my personal supervision.

Signed Dorsey M. Howe
Licensed Embalmer No. 4222
P. O. Address Lebanon, 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.

Registration District No. *110*

Primary Registration District No. *3033*

Registrar's No. _____

1. PLACE OF DEATH:

(a) County *Laclede*
 (b) City or town *Sebanon*
(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 *Murdo M. DeKoon*

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 *wid*

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

7. Birth date of deceased *Sept 29 1942*
(Month) (Day) (Year)

8. AGE: Years *42* 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 _____

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 _____
(Burial, cremation, or removal) (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 _____ year *1942* hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 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 _____

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? _____ (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

5-31683

R. M. James, M.D.
Special Agent, U.S. Public Health Service
Division of Health
Jefferson City, Missouri

Re: Murdo M. DeNoon

Dear Dr. James:

The death of Mr. DeNoon was due to a coronary insufficiency of the anterior pattern, and was not due to external causes.

Very truly yours,

Paul A. Jenkins

Paul A. Jenkins, M.D. *by d.o.*