

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 21193
Registrar's No. 6027

Registration District No. 318

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County City of Springfield

(b) City or town City of Springfield
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: City Infirmary Hospital.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6-29-48/7-6-48
(Specify whether years, months or days)

In this community 6-48
(years, months or days)

3. (a) PRINT FULL NAME John Wm Noffsinger.

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife _____

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

7. Birth date of deceased 1-16-1871
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

77 6 20 hr. min.

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

10. Usual occupation None

11. Industry or business _____

MOTHER FATHER { 12. Name Upton Noffsinger

13. Birthplace ? Unk.

14. Maiden name Mrs. Mary Maguire

15. Birthplace Ohio

16. (a) Informant City Infirmary Records.

(b) Address 5800 Arsenal St.

17. (a) Burial (b) Date thereof 7/8/48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St Peter's Central Und.C

18. (a) Signature of funeral director J. F. Breder

(b) Address 1841 Cass Ave

19. (a) Jul 7 1948 (b) J. F. Breder
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County woe

(c) City or town City
(If outside city or town limits, write "RURAL")

(d) Street No. 936 N8th St.
25 (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 6
year 48 hour 1; minute 15 a.m.

21. I hereby certify that I attended the deceased from 6-29, 1948 to 7-6, 1948
that I last saw h. im alive on 7-6, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia Duration 3 days

Due to Chronic Senile Emphysema

Due to _____

Other conditions 187
(include pregnancy within 3 months of death)

PHYSICIAN

Major findings:
Of operations _____

Of autopsy Same

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)

(e) Means of injury _____

Signature Masso Thomas (M.D. or other) _____

Address 5800 Arsenal Date signed 7/6/48

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

Gustav W. Bintlack

Licensed Embalmer No.

4329

P. O. Address

St. Louis, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.