

FILED AUG 8 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 23087

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 693

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD.

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY Greene	
b. CITY (If outside corporate limits, write RURAL and give township) Springfield	c. LENGTH OF STAY (In this place) 1 DAY	c. CITY (If outside corporate limits, write RURAL and give township) Springfield	
d. FULL NAME OF HOSPITAL OR INSTITUTION Burge Hospital		d. STREET ADDRESS (If rural, give location) 2020 N. Travis	

3. NAME OF DECEASED (Type or Print)	a. (First) Murtle	b. (Middle) Golden	c. (Last) Noston	4. DATE OF DEATH (Month) (Day) (Year)	Aug 4 1949
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED—NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH July 25-1892	9. AGE (In years last birthday) 57	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 2 HRS. Hours	IF UNDER 15 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.	10b. KIND OF BUSINESS OR INDUSTRY In Home	11. BIRTHPLACE (State or foreign country) Mo D	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Allen F. Best	13b. MOTHER'S MAIDEN NAME hilly hee	14. NAME OF HUSBAND OR WIFE Charles Noston
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give date of service) No	16. SOCIAL SECURITY NO. UNKNOWN	17. INFORMANT'S SIGNATURE OR NAME HUSBAND	ADDRESS Same as pt.
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute dilatation of heart		2 days
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Chronic myocarditis		3 yrs.
DUE TO (c) Chronic glomerulo-nephritis		3 yrs.	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Deminerlization of bones with flattening of vertebrae + bending of descending aorta		1 yr.	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
		572X

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **Aug 1948**, to **4 Aug 1949**, that I last saw the deceased alive on **3 Aug 1949**, and that death occurred at **5:30 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE Samuel E. Pratt M.D.	23b. ADDRESS 1630 N Jefferson	23c. DATE SIGNED 4 Aug 49
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 8-6-49	24c. NAME OF CEMETERY OR CREMATORY GREENLAWN	24d. LOCATION (City, town, or county) (State) SPRINGFIELD MO.
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DATE REC'D BY LOCAL REG. 8-5-49	REGISTRAR'S SIGNATURE W.S. Handley	FUNERAL DIRECTOR'S SIGNATURE J. N. Klingner + Co.	ADDRESS Spfld Mo.
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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.....

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed

Ogle Stone Jr.

Licensed Embalmer No.

4176

P. O. Address

Springfield

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.