

FILED MAY 5 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

13587

State File No. ....

0520  
1

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

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 169 PRIMARY REG. DIST. NO. 4258 Registrar's No. 22

|  |                                  |  |  |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>KNOX</u>   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>MISSOURI</u> b. COUNTY <u>KNOX</u>   |  |
| b. CITY (If outside corporate limits, write RURAL and give town) <u>EDINA</u>  |                                  | c. CITY (If outside corporate limits, write RURAL and give township) <u>EDINA</u> 1570   |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION  |                                  | d. STREET ADDRESS (If rural, give location) <u>0</u>   |  |
| 3. NAME OF DECEASED<br>a. (First) <u>APPLONIA</u><br>(Type or Print)   |                                  | b. (Middle) <u>CLARA</u>   |  |
| c. (Last) <u>NOBLITT</u>   |                                  | 4. DATE OF DEATH (Month) (Day) (Year)<br><u>APRIL 21 1950</u>  |  |
| 5. SEX <u>1</u><br><u>FEMALE</u>   | 6. COLOR OR RACE<br><u>WHITE</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br><u>MARRIED</u>   | 8. DATE OF BIRTH<br><u>JAN. 27, 1867</u>                     |
| 9. AGE (In years last birthday) <u>83</u>  |                                  | IF UNDER 1 YEAR<br>Months <u>2</u> Days <u>24</u>  | IF UNDER 24 HRS.<br>Hours <u>0</u> Min. <u>0</u>             |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>HOUSEWIFE</u>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY  | 11. BIRTHPLACE (State or foreign country)<br><u>MISSOURI</u> |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |                                  | 13a. FATHER'S NAME<br><u>JOSEPH KLOTE</u>  |  |
| 13b. MOTHER'S MAIDEN NAME<br><u>THOMAS L. NOBLITT</u>  |                                  | 14. NAME OF HUSBAND OR WIFE  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No</u>  |                                  | 16. SOCIAL SECURITY NO.  |  |
| 17. INFORMANT'S SIGNATURE OR NAME<br><u>Geneva J. Lang</u>   |                                  | ADDRESS<br><u>Edina</u>  |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthma, etc.—It means the disease, injury, or complication which caused death.                                  |                                  | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral accident</u><br>ANTECEDENT CAUSES<br>Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <u>hypertension</u><br>DUE TO (c) <u>Arteriosclerosis - Cardiovascular</u><br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.<br><u>acute Cholecystitis</u> |  |
| INTERVAL BETWEEN ONSET AND DEATH<br><u>1 day</u><br><u>years</u><br><u>442 X</u>   |                                  | 19a. DATE OF OPERATION   |  |
| 19b. MAJOR FINDINGS OF OPERATION   |                                  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 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)  |                                  | 21d. TIME OF INJURY (Month) (Day) (Year) (Hour)  |  |
| 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                                  | 21f. HOW DID INJURY OCCUR?   |  |
| 22. I hereby certify that I attended the deceased from <u>June 15, 1949</u> , to <u>April 21, 1950</u> , that I last saw the deceased alive on <u>4-20, 1950</u> , and that death occurred at <u>1:30 P.M.</u> , from the causes and on the date stated above. |                                  |  |  |
| 23a. SIGNATURE<br><u>Diamond Billingsley</u>   |                                  | 23b. ADDRESS<br><u>St. Joseph Hospital &amp; Clinic</u>  |  |
| 23c. DATE SIGNED<br><u>4/22/50</u>   |                                  | 24a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL (1)</u>   |  |
| 24b. DATE<br><u>APRIL 24-1950</u>  |                                  | 24c. NAME OF CEMETERY OR CREMATORY<br><u>ST. JOSEPH'S CATHOLIC Cem</u>   |  |
| 24d. LOCATION (City, town, or county) (State)<br><u>EDINA MISSOURI</u>   |                                  | DATE REC'D BY LOCAL REG.<br><u>4-22-50</u>   |  |
| REGISTRAR'S SIGNATURE<br><u>Nelle S. Nunneley</u>  |                                  | 25. FUNERAL DIRECTOR'S SIGNATURE<br><u>Paul C. Krieger</u>   |  |
| ADDRESS<br><u>Edina Mo.</u>  |                                  | ADDRESS  |  |

RECEIVED MAY 2 195

District Health Officer No.

District File Number.....

*Don Filed* .....

**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 *Paul C. Kieghauser*

Licensed Embalmer No. *4085*

P. O. Address *Edina Missouri*

**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.