

# STANDARD CERTIFICATE OF DEATH

State File No. **3849**

BIRTH NO. **FILED FEB 17 1954** REG. DIST. NO. **1** PRIMARY REG. DIST. NO. **3000** Registrar's No. **33**

1. PLACE OF DEATH a. COUNTY <b>Adair</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Mo.</b> b. COUNTY <b>Adair</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Kirksville</b>		c. CITY OR TOWN <b>Novinger</b>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. LENGTH OF STAY (In this place) <b>2 wks</b>		e. STREET ADDRESS (If rural, give location) <b>R.F.D. #1</b>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>Laughlin Hospital</b>			

3. NAME OF DECEASED (Type or Print)	a. (First) <b>Mary</b>	b. (Middle) <b>Francis</b>	c. (Last) <b>Novinger</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>Feb. 8, 1954</b>
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5. SEX <b>F</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>April 12, 1870</b>	9. AGE (In years last birthday) <b>83</b>	IF UNDER 1 YEAR Months	IF UNDER 1 Hrs. Hours	IF UNDER 1 Min. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Home</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Sullivan County, Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
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13a. FATHER'S NAME <b>John N. Albright</b>	13b. MOTHER'S MAIDEN NAME <b>Nancy Brown</b>	14. NAME OF HUSBAND OR WIFE <b>Joe Novinger</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>	16. SOCIAL SECURITY NO. <b>X</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. John Mathew, Novinger, Mo.</b>	ADDRESS
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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, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Coronary Thrombosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) _____  DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Generalized Arteriosclerosis ?</b>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <b>4/201</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **Dec 14, 1953**, to **Feb 8, 1954**, that I last saw the deceased alive on **Feb 8, 1954**, and that death occurred at **10:15 A. m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>D. E. Rhoads D.O.</b>	23b. ADDRESS <b>Kirksville, Mo.</b>	23c. DATE SIGNED <b>2-9-54</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>2/11/54</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Novinger,</b>	24d. LOCATION (City, town, or county) (State) <b>Novinger, Mo.</b>
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DATE REC'D BY LOCAL REG. <b>2-10-54</b>	REGISTRAR'S SIGNATURE <b>Kate Lambert</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Bob Lee</b>	ADDRESS <b>Kirksville Mo.</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

**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.....  
Signature of Student Embalmer

Signed *George W. Davall* .....

Licensed Embalmer No. *479*

P. O. Address *Kirksvik* .....

**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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.**