

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

38690

FILED DEC 2 1955

State File No. 10217

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10217

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Illinois</b> b. COUNTY _____					
b. CITY OR TOWN <b>St. Louis, Mo.</b>		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN <b>Blumound.</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b>				e. STREET ADDRESS (If rural, give location) <b>Route #2</b>					
3. NAME OF DECEASED (Type or Print) a. (First) <b>Ruth</b>		b. (Middle) <b>Irene</b>		c. (Last) <b>Noland</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>Nov. 22, 1955</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>June 9, 1896</b>			
9. AGE (in years last birthday) <b>59</b>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <b>Blumound, Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13a. FATHER'S NAME <b>Thomas D. Scott</b>		13b. MOTHER'S MAIDEN NAME <b>M. Jane Boyles</b>		14. NAME OF HUSBAND OR WIFE <b>Chas. F. Noland</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Chas. F. Noland Blumound, Ill.</b>					
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.				MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Generalized Peritonitis</b>				DUPLICATE (b) <b>Carcinoma of Rectum with metastases</b>				<b>6 days</b>	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.				DUPLICATE (c) _____				<b>6 mos.</b>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.									
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <b>154x</b>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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 <b>Nov. 12, 1955</b> , to <b>Nov. 22, 1955</b> , that I last saw the deceased alive on <b>Nov. 22, 1955</b> , and that death occurred at <b>9:25 A. M.</b> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <b>E. J. Vermillion M.D.</b>				23b. ADDRESS <b>BARNES HOSPITAL</b>		23c. DATE SIGNED <b>11/22/55</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>		24b. DATE <b>11-22-55</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Blumound, Illinois</b>		24d. LOCATION (City, town, or county) (State) _____			
DATE REC'D BY LOCAL REG. <b>NOV 22 1955</b>		REGISTRAR'S SIGNATURE <b>J. Earl Smith M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Gleason &amp; Sons 6175 Delmar</b>					

(Licensed Embalmer's Statement on Reverse Side)

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

JUL 28 1958

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 *Joe E. McCulloch*

Licensed Embalmer No. *246*

P. O. Address *6173-D*

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.