

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-029759

FILED VS AUG 27 1959 200

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 141

| | | | | | | | | | | | | | |
|--|--|--|--|---|---|--|---|---|--|--|-------|--|--|
| 1. PLACE OF DEATH a. COUNTY Macon | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Adair | | | | | | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Hudson Township | | Length of stay in 1b 38 hours | | c. CITY OR TOWN Novinger | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | | | | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Still Children Osteopathic Sanatorium | | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) R. F. D. #2 | | Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Minnie Middle V. Last Novinger | | | | 4. DATE OF DEATH Month 8 Day 22 Year 1959 | | | | | | | | | |
| 5. SEX Female | | 6. COLOR OR RACE white | | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH 9/7/1890 | | 9. AGE (last birthday) 68 | | IF UNDER 1 YEAR Months _____ Days _____ | | IF UNDER 24 HR Hours _____ Min. _____ | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home | | | 10b. KIND OF BUSINESS OR INDUSTRY Home | | | 11. BIRTHPLACE (City and state or country) Adair County Mo. | | | 12. CITIZEN OF WHAT COUNTRY U. S. A. | | | | |
| 13a. FATHER'S NAME Aaron Shoop | | | | 13b. MOTHER'S MAIDEN NAME Isabelle Shoop | | | | 14. NAME OF HUSBAND OR WIFE W. H. Novinger | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT Address W. H. Novinger, Novinger, Mo. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Suffocation & Strangulation DUE TO (b) Suicide DUE TO (c) Hanging Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH Inst. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | | | | | | | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | | | | | | | | | |
| 20c. TIME OF INJURY Hour _____ p.m. | | Month, Day, Year | | | | | | | | | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 20f. CITY, TOWN, OR LOCATION | | | COUNTY | | STATE | | |
| 21. I attended the deceased from _____ to _____ and last saw ^{her} _{him} alive on _____ Death occurred at App. 7:00 A.m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | | | | | |
| 22a. SIGNATURE (Degree or title) Lester Shotton (Coroner) | | | | | | 22b. ADDRESS Macon, Mo. | | | | 22c. DATE SIGNED 8/24/59 (State) | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 8/24/59 | | 23c. NAME OF CEMETERY OR CREMATORY Novinger Cemetery | | | 23d. LOCATION (City, town, or county) Novinger, Mo. | | | | | | |
| 24. FUNERAL DIRECTOR Paul M. Wiley | | | | ADDRESS Kirksville, Mo, | | | | 25. DATE RECD. BY LOCAL REG. 8/22/59 | | 26. REGISTRAR'S SIGNATURE W. H. Neely | | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed George W. Davel

Licensed Embalmer No. 4799

P. O. Address Kirkville

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.