

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-040929

FILED VS. NOV 17 1959

200

Primary Registration District No. 3041

Registrar's No. 184

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY <u>MACON</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>SHELBY</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>MACON</u>		Length of stay in 1b <u>14 DAYS</u>		c. CITY OR TOWN <u>CLARENCE</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>SAMARITAN HOSPITAL</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>CLARENCE MO</u>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>FLORENCE</u> Last <u>NOEL</u>				4. DATE OF DEATH Month <u>OCT</u> Day <u>23</u> Year <u>1959</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>04 25 1878</u>	9. AGE (last birthday) <u>80</u>	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) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSE WIFE</u>		11. BIRTHPLACE (City and state or country) <u>CLARENCE MO</u>		12. CITIZEN OF WHAT COUNTRY <u>US</u>	
13a. FATHER'S NAME <u>WM. E. GRISWOLD</u>			13b. MOTHER'S MAIDEN NAME <u>FRANCIS VELMA WILSON</u>		14. NAME OF HUSBAND OR WIFE <u>JAMES E. NOEL</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>MRS JOHN QUINLEY CLARENCE MO</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Terminal broncho pneumonia</u>							<u>4 days</u>
DUE TO (b) <u>Cerebral vascular accident</u>							<u>10 days</u>
DUE TO (c) <u>Arteriosclerosis</u>							<u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Pernicious Anemia</u>							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 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 _____ a.m. _____ 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 <u>July 16, 1953</u> to <u>Oct 23, 1959</u> and last saw her alive on <u>Oct 23, 1959</u> Death occurred at <u>5:45 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Alan R. Hill D.O.</u>				22b. ADDRESS <u>Clarence, MO</u>		22c. DATE SIGNED <u>10-30-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>10-25-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MAPLEWOOD CEMETERY</u>		23d. LOCATION (City, town, or county) <u>CLARENCE MO</u>		STATE	
24. FUNERAL DIRECTOR <u>GREENING CLARENCE MO</u>			ADDRESS		25. DATE RECD. BY LOCAL REG. <u>10/30/59</u>	26. REGISTRAR'S SIGNATURE <u>W. C. Mueely</u>	

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 me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Charles C. Green

Licensed Embalmer No. 4625

P. O. Address Clarence

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.