

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-041353

FILED VS DEC 3 1959

294

3056

268

STATE FILE NUMBER

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

NDED

1. PLACE OF DEATH a. COUNTY <b>Randolph</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Randolph</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Moberly</b>	Length of stay in 1b <b>52 Yrs</b>	c. CITY OR TOWN <b>Moberly</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Woodland Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>403 Farror</b>
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <b>MYRTLE</b> Middle <b>ANNA</b> Last <b>NOELL</b>			4. DATE OF DEATH Month <b>NOV.</b> Day <b>25</b> Year <b>1959</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>7-4-1886</b>	9. AGE (last birthday) <b>73</b>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days 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 country) <b>Wellsville, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Fielding Hayes</b>		13b. MOTHER'S MAIDEN NAME <b>Liza Jane Peery</b>		14. NAME OF HUSBAND OR WIFE <b>John Robert Noell</b>		
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>None</b>	17. INFORMANT <b>J. R. Noell</b>		Address <b>Moberly</b>	

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) <b>Cerebral hemorrhage due to hypertensive cardiovascular disease.</b>		<b>20 hours</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	<b>Diabetes mellitus</b>	<b>?</b>
DUE TO (c)		

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	
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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 **Nov. 24, 1959** to **Nov. 25, 1959** and last saw her <sup>her</sup> <sub>1959</sub> alive on **Nov. 25, 1959**  
 - Death occurred at **6:00** a. \_\_\_\_\_ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>J. Will Fleming, Jr.</i> (Degree or title) <b>J. Will Fleming, Jr., M.D.</b>	22b. ADDRESS <b>Moberly, Mo.</b>	22c. DATE SIGNED <b>11-27-59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>11-27-1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Wellsville</b>	23d. LOCATION (City, town, or county) (State) <b>Wellsville Mo.</b>
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24. FUNERAL DIRECTOR <b>Mahan Funeral Service</b> ADDRESS <b>Moberly</b>	25. DATE RECD. BY LOCAL REG. <b>11-27-59</b>	26. REGISTRAR'S SIGNATURE <i>Seaburn</i>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS DEC 3 1959

**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

*John A. Green*

Licensed Embalmer No. 3815

P. O. Address Moford

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.