

REGISTRATION DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-045141

STATE FILE NUMBER

Registration District No. 38 Primary Registration District No. 3096 Registrar's No. 712

1. PLACE OF DEATH a. COUNTY <u>Boone</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>Columbia Mo.</u>		Length of stay in 1b <u>3 mo. + 2 days</u>		c. CITY OR TOWN <u>CHARENCE</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>University Medical Center</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Vernie</u> Middle <u>Lyle</u> Last <u>Noek</u>				4. DATE OF DEATH Month <u>12</u> - Day <u>23</u> - Year <u>60</u>					
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>10-23-94</u>	9. AGE (last birthday) <u>62</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>owner of filling station</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>CHARENCE Mo</u>		11. BIRTHPLACE (City and state or country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY		
13a. FATHER'S NAME <u>Jim Noek</u>			13b. MOTHER'S MAIDEN NAME <u>FLORENCE Griswold</u>			14. NAME OF HUSBAND OR WIFE <u>Erma Noek</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>486-34-6722</u>		17. INFORMANT <u>University of Mo. Medical Records</u> Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anuria and uremia</u> DUE TO (b) <u>Kimmelstiel Wilson's Disease</u> DUE TO (c) <u>Diabetes Mellitus</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>1 month</u> <u>7 months</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Septicemia, Generalized Arteriosclerosis, Diabetic Neuropathy</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>9-21-60</u> to <u>12-23-60</u> and last saw him alive on <u>12-23-60</u> Death occurred at <u>2:00</u> <u>a</u> m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>J. Harold Hartley M.D.</u>				22b. ADDRESS <u>University Med. Center, Columbia</u>		22c. DATE SIGNED <u>12-23-60</u>			
23a. BURIAL: CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>12-23-60</u>	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) <u>Charance</u>		23e. STATE <u>Mo</u>			
24. FUNERAL DIRECTOR <u>Herbert General Service Co. 1266 Columbia</u> (Licensed Embalmer's Statement on Reverse Side)			25. DATE RECD. BY LOCAL REG. <u>Dec 23 1960</u>		26. REGISTRAR'S SIGNATURE <u>TRMB RE PalmdH</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 _____
 or by _____, Student Embalmer No. _____
 working under my personal supervision.

Student _____
 Signature of Student Embalmer

Signed George A. Kerby

Licensed Embalmer No. 16757

P. O. Address Columbia

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.