

COURT DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-012464

STATE FILE NUMBER

Registration District No. 4 Primary Registration District No. _____ Registrar's No. 49

AMENDED

1. PLACE OF DEATH **MAY 10 1961**

a. COUNTY **Atchison**

b. CITY (If outside corporate limits, give TOWNSHIP only) **Fairfax** Length of stay in 1b **27 hrs**

c. CITY OR TOWN **Tarkio** Inside Limits Yes No

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION **Fairfax Community Hosp** Inside Limits Yes No

d. STREET ADDRESS (If outside, give location) Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First Middle Last 4. DATE OF DEATH Month Day Year

SAMUEL N NOBLE **April 11, 1961**

5. SEX **male** 6. COLOR OR RACE **white** 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH **12/30/1882** 9. AGE (last birthday) **78**

IF UNDER 1 YEAR Months **3** Days **11** IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **ret'd farmer** 10b. KIND OF BUSINESS OR INDUSTRY **general** 11. BIRTHPLACE (City and state or country) **Albany, Missouri.** 12. CITIZEN OF WHAT COUNTRY **U.S.**

13a. FATHER'S NAME **Frank Noble** 13b. MOTHER'S MAIDEN NAME **Margaret Hatcher** 14. NAME OF HUSBAND OR WIFE **Margaret**

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 **Beldon Noble** Address **Tarkio, Mo.**

18. CAUSE OF DEATH (Enter only one cause per (a), (b), and (c). PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Terminal uraemia**

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) **Hypertensive arteriosclerotic cerebrovascular disease**

DUE TO (c) **Brochial pneumonia, Cor pulmonale**

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. Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT SUICIDE HOMICIDE 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 NOT WHILE AT WORK 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ 20f. CITY, TOWN, OR LOCATION **Tarkio, Mo.** COUNTY **Atchison** STATE **Mo.**

21. I attended the deceased from **2/8/60** to **4/11/61** and last saw him on **4/11/61** Death occurred at **10:00 p.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE **[Signature]** (Degree or title) _____ 22b. ADDRESS **Tarkio, Mo.** 22c. DATE SIGNED **4/14/61**

23a. BURIAL, CREMATION/REMOVAL (Specify) **burial** 23b. DATE **4/14/61** 23c. NAME OF CEMETERY OR CREMATORY **Grange Hall Cemetery** 23d. LOCATION (City, town, or county) (State) **Rock Port, Mo.**

24. FUNERAL DIRECTOR **Davis Funeral Home** ADDRESS **Tarkio, Mo.** 25. DATE RECD. BY LOCAL REG. **May 3, 1961** 26. REGISTRAR'S SIGNATURE **[Signature]**

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

Frost R. Browning

Licensed Embalmer No. 3338

P. O. Address Tarkio, Mo.

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.