MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

14

1. PLACE OF DEATH
County Adair — Registration District No. 4 — File No.
Township — Primary Registration District No. 3001 — Registered No. 17
City Kirksville (No. ..... St. ..... Ward)

2. FULL NAME Peter O. Noren
(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Anna Noren

6. DATE OF BIRTH (MONTH, DAY AND YEAR): 11-4-1865

7. AGE: Years 63 — Months 2 — Days 8 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Engineer
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: O

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Sweden

PARENTS
10. NAME OF FATHER: Andrew Noren
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Sweden
12. MAIDEN NAME OF MOTHER: ✓
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Sweden

14. INFORMANT: Mrs Geo. Korn
(Address) 420 W. Missouri St. Kirksville

15. FILED 1/14, 1929 — C. H. Becker, Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Jan 12 1929

17. I HEREBY CERTIFY, That I attended deceased from on Jan 12, 1929, to ..... 19..., that I last saw him alive on Did not see him alive 19..., and that death occurred, on the date stated above, at 2:10 (about) p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: 93 D
Myocarditis
(I was called to pronounce him dead but he had been loosening for above ailment unknown to me)
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY): Influenza
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? no. DATE OF .....
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? physical exam & history
(Signed) Earl F. Morris, M.D.
Jan 14, 1929 (Address) 716 E. Scott, Kirksville, Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF ~~BURIAL, CREMATION, OR~~ REMOVAL: Tolan New Mexico — DATE OF BURIAL: 1/14 1929

20. UNDERTAKER: Dee Riley — ADDRESS: Kirksville

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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1929-1-12
1865-11-4
63-2-8

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CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County: Adair — Registration District No.: 4 — File No.:

Township: — Primary Registration District No.: 3001 — Registered No.: 17

City: Kirksville (No. ..... St. ..... Ward)

2. FULL NAME Peter D. Noren

(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
M	W	M

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTY)

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTY)

14. INFORMANT .....
(Address)

15. FILED Mar 13, 1929 — G. H. Becker, Deputy — REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) ....., M. D.

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW