

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

Do not use this space.

32918

1. PLACE OF DEATH

County Jackson
Township 1st Kan
City N.C. Mo. (No. St. Lukes Hospital)

Registration District No. 391
Primary Registration District No. 1003

File No. _____
Registered No. 5746 (Ward)

2. FULL NAME

Daryl Gene Noah

(a) Residence. No. Bethany - Mo. 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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Child

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 3 - 1925

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
5 1 9

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

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) Missouri

10. NAME OF FATHER Doris Noah

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Mo.

12. MAIDEN NAME OF MOTHER Galdie Lovell

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Mo.

14. INFORMANT Doris Noah (Address) Bethany Mo.

15. FILED 10/12 19 30 W. M. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct - 12 - 1930

17. I HEREBY CERTIFY, That I attended deceased from 10/11, 1930 to 10/12, 1930, and that I last saw him alive on 10/11, 1930, and that death occurred, on the date stated above, at 4 AM 10/13.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Bacterial Inflammation of the Lungs - pneumonia & pyothorax

110 days (duration) yrs. mos. ds. None
10/11 CONTRIBUTORY Secondary infected tuberculosis (SECONDARY)
of vertebrae spine (duration) 2 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED? Home
IF NOT AT PLACE OF BIRTH _____

DID AN OPERATION PRECEDE DEATH? Yes DATE OF message

WAS THERE AN AUTO-PSY? Yes
WHAT TEST CONFIRMED DIAGNOSIS? Cross Reaction
(Signed) Frederick E. Spawig, M. D.

10-12, 1930 (Address) St Lukes Hospital

*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 Bethany, Mo. DATE OF BURIAL Oct 12 1930

20. UNDERTAKER Mrs. C. L. Forster ADDRESS 17. C. Mo.

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.

