

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

14470

Do not use this space.

1. PLACE OF DEATH
(a) County Callaway Registration District No. 104
(b) Township FULTON Primary Registration District No. 3008
(c) City FULTON (d) Street No. State Hospital # 2 Registered No. 117
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 453 Ellen Noland
(a) Residence, No. Little Blue, MO St. Jackson County (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) WIDOWED

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) AUG-2, 1858

7. AGE YEARS 82 MONTHS 9 DAYS 19 If LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Hwp
9. Industry or business in which work was done, as saw mill, bank, etc. Home
10. Date deceased last worked at this occupation (month and year) OK 11. Total time (years) spent in this occupation 41 1/2

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) MO

FATHER
13. NAME Benjamin F Jewell
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky

MOTHER
15. MAIDEN NAME Harriet Francis White
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) MO

17. INFORMANT (ADDRESS) Hospital Records

18. BURIAL, CREMATION, OR REMOVAL PLACE Kansas City DATE April 22, 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Blachman & Son Kansas City, Mo.

20. FILED April 21, 1940 W. B. Blum Local Registrar

21. DATE OF DEATH (MONTH, DAY, AND YEAR) APRIL 21, 1940

22. I HEREBY CERTIFY, That I attended deceased from Feb-11, 1939 to April 21, 1940
I last saw her alive on APRIL 21, 1940 Death is said to have occurred on the date stated above, at 5:30 AM
The principal cause of death and related causes of importance were as follows:
Bronchopneumonia 1 week
107W

Other contributory causes of importance:
Generalized Atherosclerosis
Cerebral arteriosclerosis

Name of operation..... Date of.....
What test confirmed diagnosis? Autopsy Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide?..... Date of injury....., 19.....
Where did injury occur?..... (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....
Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....
If so, specify Fornah Howard....., M. D.
(Signed) Fornah Howard (Address) State Hospital no-1 Fulton 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.

I X16603

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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 this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 14470

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 104

Primary Registration District No. 3008

Registrar's No. _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH
 (a) County Callaway
 (b) City or town Fulton
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether
 In this community _____
years, months or days)

3. (a) PRINT FULL NAME Ellen Nolan
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W
 6. (a) Single, widowed, married, divorced wid
 6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year
 7. Birth date of deceased Aug - 2 - 1858
(Month) (Day) (Year)

8. AGE: Years 82 Months 9 Days 8
(If less than one day, hr. min.)

9. Birthplace _____
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

13. Birthplace _____
(City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) June 5, 1940 (b) R. N. Crews
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State _____ (b) County _____
 (c) City or town _____
(If outside city or town limits write "RURAL")
 (d) Street No. _____
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION
 20. DATE OF DEATH Month Apr day 21
 year _____ hour _____ minute _____ M.
 21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
 that I last saw h. _____ alive on _____, 19____,
 and that death occurred on the date and hour stated above.

Immediate cause of death _____
 Due to _____
 Due to _____
 Other conditions _____
(Include pregnancy within 3 months of death)
 Major findings:
 Of operations _____
 Of autopsy _____

Duration _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____
(City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
 While at work? _____ (e) Means of injury _____
 23. Signature Jarvis Thomas (M. D. or other) _____
 Address Fulton Mo Date signed _____

SUPPLEMENTARY

S-14470