

No. 2  
-13-40  
-17-39  
X23159

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

31558

Registration District No. 704

Primary Registration District No. 3008

State File No. \_\_\_\_\_

Registrar's No. 230

1. PLACE OF DEATH:

(a) County CALLAWAY  
FULTON

(b) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Missouri Hospital No. 1  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 18 days 3  
(Specify whether years, months or days)

In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME ENOS HENRY NOIKES

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife DK.

6. (c) Age of husband or wife if alive DK. years

7. Birth date of deceased August 16 1859  
(Month) (Day) (Year)

8. AGE: Years 81 Months \_\_\_\_\_ Days 27 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Labor

11. Industry or business \_\_\_\_\_

12. Name DK.

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

14. Maiden name DK.

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

16. (a) Informant Hospital Records

(b) Address Missouri Hospital No. 1

17. (a) \_\_\_\_\_ (b) Date thereof 9/14/40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hannibal, MO.

18. (a) Signature of funeral director Geoff E. Schwartz

(b) Address Hannibal, MO.

19. (a) 9/13/40 (b) R. M. Crues  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County Marion Co.

(c) City or town HANNIBAL  
(If outside city or town limits, write "RURAL")

(d) Street No. 1700 Grape St.  
(If rural, give location)

(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September 13  
year 1940 hour 11:10 minute \_\_\_\_\_ A.M.

21. I hereby certify that I attended the deceased from August 26, 1940 to September 13, 1940  
that I last saw him alive on September 13, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death UREMIA due to prostatic obstruction.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Syphilis  
Chronic Myocarditis  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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? 10/4

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature GEMMOR (M. D. or other) \_\_\_\_\_

Address Fulton, Mo. Date signed 9-13-40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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**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, fact should be so stated above.**