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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 37994

DEC 16 1940

Registration District No. 1

Primary Registration District No. 200

Registrar's No. 275

1. PLACE OF DEATH:

(a) County Adair

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

(c) Name of hospital or institution:
Novinger, Mo.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 years (Specify whether years, months or days)

In this community 5 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Roger Samuel Novinger

3. (b) If veteran, name war _____ 3. (c) Social Security No. None

4. Sex Male 5. Color or race Female 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive, years _____

7. Birth date of deceased Sept. 25 1934
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>6</u>	<u>1</u>	<u>24</u>	hr. _____ min. _____

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

10. Usual occupation Schoolboy

11. Industry or business _____

MOTHER FATHER { 12. Name Jess R. Novinger 0

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

14. Maiden name Helen Cooper 0

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

16. (a) Informant Jess R. Novinger

(b) Address Novinger, Mo.

17. (a) Burial (b) Date thereof 11-20-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Novinger Cemetery

18. (a) Signature of funeral director Bee Riley

(b) Address Kirksville, Mo.

19. (a) Nov 28/40 (b) Spencer L. Freeman
(Date received by registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Adair

(c) City or town Novinger, Mo.
(If outside city or town limits, write "RURAL")

(d) Street No. 0 (If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 19
year 1940 hour 7:30 minute P. M.

21. I hereby certify that I attended the deceased from Nov 11
1940 to Nov 19 19 40

that I last saw him alive on Nov 19 19 40
and that death occurred on the date and hour stated above.

Immediate cause of death: Acute anterior Poliomylitis Duration 8 days

Due to _____

Due to _____

Other conditions: Pertussis 40 days
(Include pregnancy within 3 months of death)

Major findings: None PHYSICIAN _____

Of operations _____
Of autopsy _____
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? _____

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

23. Signature H. J. Garrison M.D. (Physician)
Novinger Mo (Registrar)
Address _____ Date signed 11-20-40

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

RECEIVED

District Health Officer No. 10

District File Number 12-40-2337

Date Filed DEC 14 1940

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 *H. E. Kelly*
Licensed Embalmer No. ~~1234~~ 3808
P. O. Address *Kentville MD*

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. 37994

Registration District No. 1

Primary Registration District No. 1

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Adair

(b) City or town Norwinger
(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)

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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Roger Samuel Norwinger

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: month Nov day 19
year 1950 hour _____ minute _____ M.

4. Sex M 5. Color or race Wch

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

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if
alive _____ year _____

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 _____

7. Birth date of deceased: (Month) _____ (Day) _____ (Year) _____

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ hr _____ min.

Due to _____

Due to _____

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

10. Usual occupation _____

11. Industry or business _____

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: (Month) _____ (Day) _____ (Year) _____

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) Jan 3/41 (b) Spencer L. Freeman
(Date received local registrar) (Registrar's signature)

Other conditions (include pregnancy within 3 months of death) _____

Major findings:
Of operations _____

Of autopsy _____

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? _____

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

23. Signature H. T. Garrison (M. D. or other) _____

Address Norwinger Mo Date signed _____

SUPPLEMENTAL

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

