No. 2
10-39

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

6813

State File No.

FILED MAR 18 1942

Registration District No. 340391 Primary Registration District No. 55461230 Registrar's No. 13

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

1. PLACE OF DEATH:
(a) County St Francois Iron
(b) City or town Bismarck Mo Ironton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Ironton Hospital Ironton Mo
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Feb. 18-1942 (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County St Francois
(c) City or town Bismarck
(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.

3. (a) PRINT FULL NAME Little Dorothy Susan Noll
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Child
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased February (Month) 19 (Day) 1939 (Year)
8. AGE: Years 2 Months Days 3. If less than one day hr. min.
9. Birthplace Bismarck Mo (City, town, or county) (State or foreign country)
10. Usual occupation Child
11. Industry or business
MOTHER FATHER
12. Name Mr. Monroe Noll.
13. Birthplace Hogan Mo. (City, town, or county) (State or foreign country)
14. Maiden name Lola Hamilton
15. Birthplace Decatur Nebraska (City, town, or county) (State or foreign country)
16. (a) Informant Mrs. Lois Noll - Mother
(b) Address Bismarck, Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 24-1942 (Month) (Day) (Year)
(c) Place: burial or cremation Masonic
18. (a) Signature of funeral director Alvin W. Hoop
(b) Address 303 Crawford St. Flat River, Mo
19. (a) 3-3-42 (Date received local registrar) (b) Virgina R. Miller (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feby day 22nd year 1942 hour 19 minute 45 P. M.
21. I hereby certify that I attended the deceased from Feby 19, 1942 to Feby 22, 1942; that I last saw her alive on Feby 22, 1942 and that death occurred on the date and hour stated above.

Immediate cause of death — Duration
Due to Obstruction of Bowels
Due to
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? (Specify type of place)
While at work? (e) Means of injury
23. Signature E. W. Gale (M. D. or other)
Address Bismarck Mo Date signed 2-4-42

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 4
District File Number 342-32
Date Filed 2-11-41

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 Alvin W. Hood

Licensed Embalmer No. 2780

P. O. Address 303 Crane St. Flat Rivers

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.

No. 2B
-21-41
1 X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 6813

Registration District No. 391 Primary Registration District No. 4230 Registrar's No.

1. PLACE OF DEATH:
(a) County: Iron
(b) City or town: Ironton
(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 years, months or days)
In this community

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: Luttell S. Noll
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex: M
5. Color or race: W
6. (a) Single, widowed, married, divorced: S
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased: Nov (Month) 19 (Day) 1939 (Year)

8. AGE: Years 2 Months — Days — 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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month day year hour minute M.
21. I hereby certify that I attended the deceased from 19 to 19; that I last saw him alive on 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Obstruction of bowels	
Due to	
Due to	
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)
(b) 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 (M. D. or other)
Address Date signed

SUPPLEMENTARY

1222