DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 23 1947

Registration District No. 1284

THE STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. 13161

Primary Registration District No. 2000

Registrar's No. 277

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

**1. PLACE OF DEATH:**

(a) County: Greene

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

(c) Name of hospital or institution: 1026 Mt. Vernon St.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ____ (Specify whether In this community 65 Years years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State: Missouri (b) County: Greene 39

(c) City or town: Springfield 2
(If outside city or town limits, write "RURAL")

(d) Street No.: 1026 Mt. Vernon St. 6
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country ____

3. (a) PRINT FULL NAME: AGNES NOAKES

3. (b) If veteran, name war: none

3. (c) Social Security No.: none

4. Sex: Female

5. Color or race: White

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

6. (b) Name of husband or wife: William Henry Noakes

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

7. Birth date of deceased: June (Month) 26, (Day) 1852 (Year)

8. AGE: Years 94 | Months 8 | Days 28 | If less than one day ____ hr. ____ min.

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

10. Usual occupation: None

11. Industry or business: None

FATHER
12. Name: Unknown
13. Birthplace: Unknown (City, town, or county) Unknown (State or foreign country) 9

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown (City, town, or county) Unknown (State or foreign country) 9

16. (a) Informant: Mrs. Annie Huxley 7

(b) Address: 1026 Mt. Vernon, Springfield, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Mar. 30, 1947 (Month) (Day) (Year)

(c) Place: burial or cremation: Clear Creek Cemetery

18. (a) Signature of funeral director: Fred C. Thieme

(b) Address: Springfield, Mo.

19. (a) 3-29-47 (Date received local registrar) (b) M. E. Handley MD (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month March day 24th year 1947 hour 5:20 P.M. minute ____ M.

21. I hereby certify that I attended the deceased from June, 1946 to March 24, 1947 that I last saw her alive on MARCH 24, 1947 and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death: Pneumonia and | |
| Chronic Myocarditis | |
| 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)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place) 2

While at work? (e) Means of injury

23. Signature: D. F. Youll (M. D. or other) D.O.

Address: Springfield, Mo. Date signed: 3/25/47

111

(Licensed Embalmer's Statement on Reverse Side)

## 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 Ralph H. Thieme

Licensed Embalmer No. 3681

P. O. Address Springfield, Mo.

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**

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

COMMERCE
CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. May

...rict No. 128 Primary Registration District No. 2000 Registrar's No. 277

SUPPLEMENTARY

1. PLACE OF DEATH:
(a) County Greene
(b) City or town Springfield
(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 Agner Noaker
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 years
7. Birth date of deceased June (Month) 26 (Day) 1850 (Year)
8. AGE: Years 94 Months 8 Days 28 If less than one day hr. min.
9. Birthplace (City, town, or county) Maryland (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 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 March 24
year 1947 hour minute M.
21. I hereby certify that I attended the deceased from November 46
, 19 , to , 19 ;
that I last saw her alive on MAR 25-1947 , 19 ;
and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death: Pneumonia and Chronic Myocarditis | |
| 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) no
(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 D. F. Youll (or other) D.O
Address Springfield, Mo Date signed 4/28/47

13101

JUL 1 1947