

FILED JUL 27 1948

State File No. _____

Registration District No. 74

Primary Registration District No. 5376

Registrar's No. 37

1. PLACE OF DEATH:

(a) County DeKalb
(b) City or town Rural - "Grandriver"
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
5 miles North of Cameron, Mo.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution No (Specify whether)
In this community 18 years
(Month) (Day) (Year)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County DeKalb 33
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. 5 miles North of Cameron
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Benjamin F. Nogle

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

4. Sex Male 5. Color or race w 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Malinda Nogle 6. (c) Age of husband or wife if alive 74 years
7. Birth date of deceased Dec-9-1871
(Month) (Day) (Year)

| 8. AGE: | Years | Months | Days | If less than one day |
|---------|-----------|----------|-----------|----------------------|
| | <u>76</u> | <u>6</u> | <u>23</u> | hr. _____ min. _____ |

9. Birthplace Kent Co. Mich!
(City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business _____

12. Name B. F. Nogle
13. Birthplace Spring Field, Ohio 1
(City, town, or county) (State or foreign country)
14. Maiden name Elizabeth Shellenberger 9
15. Birthplace Arkansas
(City, town, or county) (State or foreign country)

16. (a) Informant _____
(b) Address _____

17. (a) Burial (b) Date thereof 7-5-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation De Long

18. (a) Signature of funeral director Island Funeral Home

(b) Address _____
19. (a) 7-15-48 (b) R. Davidson
(Date received local Registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 22
year 1948 hour _____ minute 12:30 P.M.

21. I hereby certify that I attended the deceased from 3-19-48
19____ to 7-2-48, 19____;
that I last saw him alive on 7-1-48, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death
Prostatic hypertrophy
decompensated
Due to _____
Due to _____

Other conditions (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? _____

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

23. Signature _____ (M.D. or other)
Address Camden, Mo Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

MOTHER FATHER

DISTRICT HEALTH OFFICE
Cameron, Mo.

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 George R. Trammell

Licensed Embalmer No. 4425

P. O. Address 309 1/2 West 3rd

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

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