

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

**FILED FEB 24 1953**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 174

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

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Springfield</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Springfield</u>	
c. LENGTH OF STAY (In this place) <u>26 years</u>		d. STREET ADDRESS (If rural, give location) <u>929 Pythian Street</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>929 Pythian Street</u>			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>LEOLA</u>	b. (Middle) <u>---</u>	c. (Last) <u>NOLAND</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 15, 1953</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>20 March 1884</u>	9. AGE (In years last birthday) <u>68</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 2 HRS. Hours _____ Mins. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Kocomo, Indiana</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Thomas Green</u>	13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE <u>Martin H. Noland</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	(If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>---</u>	17. INFORMANT'S SIGNATURE OR NAME <u>N.N. Noland</u>	ADDRESS <u>1041 S. Main Avenue, Springfield, Missouri</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>4 mo.</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Neuritis - generalized</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Unknown</u> DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<u>366 X</u>	

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____
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22. I hereby certify that I attended the deceased from 11-7, 1952, to 2-15, 1953 that I last saw the deceased alive on 2-6, 1953, and that death occurred at 4:30A. m., from the causes and on the date stated above.

23a. SIGNATURE <u>John W. Williams, M.D.</u>	(Degree or title)	23b. ADDRESS <u>Springfield, Mo</u>	23c. DATE SIGNED <u>2-16-53</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>17 Feb. 1953</u>	24c. NAME OF CEMETERY OR CREMATOR <u>Greenlawn Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Springfield, Missouri</u>
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DATE REC'D BY LOCAL REG. <u>2-17-53</u>	REGISTRAR'S SIGNATURE <u>Edith Williamson</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Frank P. Thomas</u>	ADDRESS <u>Springfield, Mo</u>
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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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed

*Ralph H. Thiene*

Licensed Embalmer No. 3681

P. O. Address Springfield, Missouri

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.