

11946

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED MAY 6 - 1957

BIRTH NO. _____		REG. DIST. NO. <u>1</u>		PRIMARY REG. DIST. NO. <u>3000</u>		Registrar's No. <u>162</u>	
1. PLACE OF DEATH a. COUNTY <u>Adair</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Lewis</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kirksville</u>		c. LENGTH OF STAY (in this place) <u>11 days</u>		c. CITY OR TOWN <u>LaBelle</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Laughlin Hospital & Clinic</u>				STREET ADDRESS (If rural, give location) <u>0560</u> <u>0</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>H orace</u>		b. (Middle) <u>Fretwell</u>		c. (Last) <u>Noel</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April 29 57</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>4-16-08</u>	
9. AGE (In years last birthday) <u>49</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 1 HR. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Lewis County, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Ben E. Noel</u>		13b. MOTHER'S MAIDEN NAME <u>Mamie Fretwell</u>		14. NAME OF HUSBAND OR WIFE <u>Lucill Hill Noel</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Ben E. Noel LaBelle, Missouri</u>			
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, assthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>Acute Myocardial Failure</u> ANTECEDENT CAUSES <u>Auricular Fibrillation</u> Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (a) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <u>Viral Hepatitis 4331C</u> Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u> <u>2 yrs</u> <u>?</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
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) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ m. _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>April 18, 1957</u> to <u>April 29, 1957</u> , that I last saw the deceased alive on <u>April 29, 1957</u> , and that death occurred at <u>12:15 pm.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>D. T. Rhoads M.D.</u>				23b. ADDRESS <u>Kirksville, Mo</u>		23c. DATE SIGNED <u>4-29-57</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>May 1, 1957</u>		24c. NAME OF CEMETERY OR CREMATORY <u>LaBelle, Mo</u>		24d. LOCATION (City, town, or county) (State) <u>LaBelle, Mo</u>	
DATE REC'D BY LOCAL REG. <u>4-29-1957</u>		REGISTRAR'S SIGNATURE <u>Doris W. Ratliff</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Laurel Coder LaBelle</u>			

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

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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
Signature of Student Embalmer

Signed

James A. Code

Licensed Embalmer No. *2532*

P. O. Address *Leicester*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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