THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-009587
STATE FILE NUMBER

MAR 19 1959 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1226

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City — Inside Limits Yes X No
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4655 E. 37th Terr. — Length of stay in 1b: 30 yrs.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Jackson
c. CITY OR TOWN Kansas City — Inside Limits Yes X No
d. STREET ADDRESS (If outside, give location) 4655 E. 37th Terr. — Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First: Bertha Middle: Last: Noel
4. DATE OF DEATH Month Day Year: March 5, 1959
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED X NEVER MARRIED WIDOWED DIVORCED
8. DATE OF BIRTH: June 6, 1889
9. AGE (In years last birthday): 69 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Practical Nurse
10b. KIND OF BUSINESS OR INDUSTRY: Nursing
11. BIRTHPLACE (City and state or country): Kansas City, Mo.
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13a. FATHER'S NAME: John E. Bleier
13b. MOTHER'S MAIDEN NAME: Teresa
14. NAME OF HUSBAND OR WIFE: Frank M. Noel
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 512-12-3129
17. INFORMANT: Julia Moschler Address: Louisberg, Kansas

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Failure — INTERVAL BETWEEN ONSET AND DEATH: 18 Mo.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Lukemia: Diagnosed Dec. 1958
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
We were Called to see the deceased in absence of her family Physician. We saw her once 2 Hours before death.
19. WAS AUTOPSY PERFORMED? YES NO X
20a. ACCIDENT SUICIDE HOMICIDE
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from One Visit 3/5/59 to 3-5-59 and last saw her alive on Mar 5-1959
Death occurred at 6 40 P m on the date stated above; and to the best of my knowledge, from the causes stated.
22a. SIGNATURE Glen H. Broyles (Degree or title) M D
22b. ADDRESS 1132 Professional Bldg.
22c. DATE SIGNED 3-6-59
23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: Mar. 6, 1959
23c. NAME OF CEMETERY OR CREMATORY: Louisberg, Cemetery
23d. LOCATION (City, town, or county) (State): Louisberg, Kansas
24. FUNERAL DIRECTOR: Stine & McClure ADDRESS: Kansas City, Mo.
25. DATE RECD. BY LOCAL REG.: 3-6-59
26. REGISTRAR'S SIGNATURE: Reva Marshall

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

Glen H. Broyles

JUN 5 1959

1:30 - 4:30

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 Thomas O. Koehler

Licensed Embalmer No. 4995

P. O. Address K.C. Mo.

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.