

**MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**FILED VS DEC 10 1959**

**59-040259**

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5717

UNRECORDED

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>JACKSON</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>		Length of stay in 1b <b>17yrs.</b>		c. CITY OR TOWN <b>KANSAS CITY</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>8421 WAYNE</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>8421 WAYNE</b>			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>BELLE</b> Middle <b>NOLAND</b> Last				4. DATE OF DEATH Month <b>NOV</b> Day <b>26</b> Year <b>1959</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>OCT 9, 1874</b>	9. AGE (last birthday) <b>85yrs.</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>RIDGELY MISSOURI</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>JACOB HOLDERMAN</b>			13b. MOTHER'S MAIDEN NAME <b>SOPHRONIA WALTERS</b>		14. NAME OF HUSBAND OR WIFE <b>OBED D. NOLAND</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	17. INFORMANT Address <b>Mrs. Stella Petro 8421 Wayne</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho pneumonia</b>						INTERVAL BETWEEN ONSET AND DEATH <b>4 d.</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b)		DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		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 <b>Sept. '57</b> to <b>26 Nov. 59</b> and last saw her <b>25 Nov. 59</b> Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>William R. Roberts, MD</b>				22b. ADDRESS <b>2108 W. 75<sup>th</sup> KC 15, Mo.</b>		22c. DATE SIGNED <b>27 Nov. 59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <b>Nov. 28, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>FAIRVIEW CEM</b>		23d. LOCATION (City, town, or county) (State) <b>LIBERTY MO.</b>			
24. FUNERAL DIRECTOR <b>D. W. NEWCOMER'S SONS K. C. MO.</b>				25. DATE RECD. BY LOCAL REG. <b>11-27-59</b>		26. REGISTRAR'S SIGNATURE <b>Norm Marshall</b>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

WILLIAM R. ROBERTS, MD

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*Chester R. Brown*

Licensed Embalmer No. 493/

P. O. Address K E Mc

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.