

MURKIN DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 4 5 0 8 5

FILED VS DEC 17 1959 294

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. 3056 Registrar's No. 274

ENDED

1. PLACE OF DEATH a. COUNTY <u>Randolph</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Randolph</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Moberly</u>		Length of stay in 1b	c. CITY OR TOWN <u>Moberly</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Community Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>123 Elizabeth</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ida</u> Middle <u>Mae</u> Last <u>Noel</u>			4. DATE OF DEATH Month <u>12</u> Day <u>5</u> Year <u>59</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>1/2/1873</u>	9. AGE (last birthday) <u>86</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>saleswoman</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Kentucky</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>John Rains</u>		13b. MOTHER'S MAIDEN NAME <u>Mathala Sterns</u>		14. NAME OF HUSBAND OR WIFE <u>T.B. Noel</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>498 38 7224</u>	17. INFORMANT Address <u>Dr. Noel Rains Moberly, Mo.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Medullary Paralysis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Cerebral Hemorrhage</u> DUE TO (c) <u>Arteriosclerosis</u>					INTERVAL BETWEEN ONSET AND DEATH <u>9 hours</u> <u>21 day</u> <u>?</u>	
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 checked="" 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 _____ a.m. _____ p.m.		Month, Day, Year				
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 <u>10-1-59</u> to <u>12-5-59</u> and last saw her ^{her} _{him} alive on <u>12-5-59</u> Death occurred at <u>1:00 AM</u> m on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <u>G. Noel Rains D.O.</u> (Degree or title)			22b. ADDRESS <u>Moberly, Mo</u>		22c. DATE SIGNED <u>12-6-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12/7/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oakland</u>		23d. LOCATION (City, town, or county) <u>Moberly, Missouri</u> (State)		
24. FUNERAL DIRECTOR <u>Marion E. Million</u> ADDRESS <u>Moberly, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>12-7-59</u>	26. REGISTRAR'S SIGNATURE <u>Reablowe</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 Merion E. Miller

Licensed Embalmer No. 3957

P. O. Address Moberly, Miss

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.