

COURT DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

61-042044

STATE FILE NUMBER

AMENDED

Registration District No. 297 Primary Registration District No. 6222 Registrar's No. 160

FILED DEC 12 1961

1. PLACE OF DEATH a. COUNTY <u>Ray</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Ray</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Richmond TOWNSHIP</u>		Length of stay in 1b <u>12 hrs</u>		c. CITY OR TOWN <u>Lawson</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>Ray County Hospital</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>St not listed</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>SOHN</u> Middle <u>THEODORE</u> Last <u>NOLKER</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>4</u> Year <u>1961</u>									
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>May 10, 1884</u>		9. AGE (last birthday) <u>77</u>		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) <u>Retired farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Lawson Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>					
13a. FATHER'S NAME <u>William Frederick Nolker</u>				13b. MOTHER'S MAIDEN NAME <u>Judith Caroline Trigg Buford Nolker</u>				14. NAME OF HUSBAND OR WIFE <u>Buford Nolker</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>494-40-6545</u>		17. INFORMANT <u>Mrs Buford Nolker Lawson mo</u> Address _____							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) <u>Anoxia</u>													
DUE TO (b) <u>Bilateral Bronchopneumonia</u>										<u>2 wks.</u>			
DUE TO (c) <u>Debility from Metastatic Carcinoma of Liver</u>										<u>4 mos</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Arteriosclerosis - Hypertension</u>										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 _____ Month, Day, Year _____ a.m. _____ p.m. _____													
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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>10-21-60</u> to <u>12-3-61</u> and last saw him alive on <u>12-3-61</u> Death occurred at <u>12:30 - 1:00</u> a.m. on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <u>A.L. Pfauth, P.O.</u>						22b. ADDRESS <u>Lawson, Mo.</u>			22c. DATE SIGNED <u>12-4-61</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Dec. 5, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>		23d. LOCATION (City, town, or county) <u>Ray County</u>		STATE <u>Mo</u>					
24. FUNERAL DIRECTOR <u>Janner Funeral Home</u>				ADDRESS <u>Lawson Mo</u>		25. DATE RECD. BY LOCAL REG. <u>12-8-1961</u>		26. REGISTRAR'S SIGNATURE <u>Malcol Jackson</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 me,

~~or by~~ _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed Ralph Van Ledingham

Licensed Embalmer No. 4009

Geelver Springs, W.
P. O. Address

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.