

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

67-0035619
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB
AMENDED

VS 300
Rev. 4/59

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USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED 8-29-67

INSTEAD OF Life

SHOULD READ 68 days

ITEM NO. 1b

BY AFFIDAVIT OF Nathaniel W. Medical Director

FILED SEP 19 1967

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4447

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		c. CITY OR TOWN Independence	
Length of stay in 1b 68 days		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Jackson County Hospital		d. STREET ADDRESS (If outside, give location) 808 South Hardy	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last John P Noland			4. DATE OF DEATH Month Day Year Aug. 25, 1967
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6/12/1887
9. AGE (last birthday) 80		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) Machine Shops-Retired		10b. KIND OF BUSINESS OR INDUSTRY Machine Shops	11. BIRTHPLACE (City and state or country) Independence, Mo.
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME George Noland	
13b. MOTHER'S MAIDEN NAME Mattie Ramsey		14. NAME OF HUSBAND OR WIFE Bula Noland	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, go, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 486 16 4694	17. INFORMANT Address Bula Noland 808 S. Hardy
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i>			INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) <i>Arteriosclerotic Heart Disease, Atrial fibrillation</i>			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Chronic pulmonary emphysema, uremia, arteriolar nephrosclerosis</i>			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 6-19-67 to 8-25-67 and last saw him alive on 8-25-67			
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) <i>Nathaniel Wuer, M.D.</i>		22b. ADDRESS <i>Memorah Medical Center</i>	22c. DATE SIGNED 8-25-67
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 8/27/67	23c. NAME OF CEMETERY OR CREMATORY Concord Cemetery	23d. LOCATION (City, town, or county) (State) Rates City, Missouri
24. FUNERAL DIRECTOR ADDRESS Earp & Sons 4707 Truman Rd., K.C., Mo.		25. DATE RECD. BY LOCAL REG. 8-26-67	26. REGISTRAR'S SIGNATURE <i>Rutherford Boyd</i>

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 John D. Hurdin

Licensed Embalmer No. 5380

P. O. Address F.C., 1110.

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.