

Registration District No. 81/220

Primary Registration District No. _____

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Scott
(b) City or town Commerce
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community, 13 days
years, months or days

3. (a) PRINT FULL NAME Gerald Dae Noland

8. (b) If veteran, name war. ✓ 3. (c) Social Security No. ✓

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced. child

6. (b) Name of husband or wife. ✓ 6. (c) Age of husband or wife if alive ✓ years

7. Birth date of deceased. Feb. 19, 1940
(Month) (Day) (Year)

8. AGE: Years — Months — Days 13 If less than one day
hr. _____ min. _____

9. Birthplace Commerce Mo
(City, town, or county) (State or foreign country)

10. Usual occupation ✓

11. Industry or business ✓

MOTHER FATHER
12. Name Lloyd Noland
13. Birthplace Cape Co Mo
(City, town, or county) (State or foreign country)
14. Maiden name Stella Mayberry
15. Birthplace Stoddard Co Mo
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Lloyd Noland
(b) Address Commerce, Mo.

17. (a) Borish (b) Date thereof 21 2/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Lake Commerce

18. (a) Signature of funeral director Risplinghoff Hubbert
(b) Address Illmo, Mo.

19. (a) 3-5-40 (b) Mrs Addie Held
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Scott
(c) City or town Commerce
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 2
year 1940 hour 3 minute — M.

21. I hereby certify that I attended the deceased from Feb. 19-40
to Feb. 2, 19 40
that I last saw him alive on Feb 1, 19 40
and that death occurred on the date and hour stated above.

Immediate cause of death
Pneumonia BIRTH
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: _____
Of operations _____
Of autopsy _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) ✓
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? ✓

(Specify type of place) _____
While at work _____ (e) Means of injury _____

23. Signature M. J. Davis (M. D. or other) _____
Address Illmo Mo Date signed 2/4/40

MARGIN RESERVED FOR BINDING

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

RECEIVED

District Health Officer No. 2,

District File Number 340-768

Date Filed 3/13/40

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

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 this body is not embalmed, above space should be left blank.