MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

38879

1. PLACE OF DEATH

County..... Registration District No. 791 File No.....

Township..... Primary Registration District No. 1003 Registered No. 8435

City City Hosp. (Institution Euclid City Hospital St. ..... Ward)

2. FULL NAME Allen (Norris) Norris

(a) Residence. No. 2351 Lafayette St. 23 Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Female	White	Married

5a. IF MARRIED, WIDOWED, OR DIVORCED ~~HUSBAND OF~~ (OR) WIFE OF Mr. J. W. Norris

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 14 1887

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	40	3	7	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House-Wife
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer At Home

9. BIRTHPLACE (CITY OR TOWN) Belleau
(STATE OR COUNTRY) Ill.

PARENTS

10. NAME OF FATHER John A Cooley

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY) Illinois

12. MAIDEN NAME OF MOTHER Abby La Bee

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY) Illinois

14. INFORMANT J. W. Norris
(Address) 2351 Lafayette

15. FILED SEP 22 1927 Mary C. Starkloff
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept. 21 1927

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19...
that I last saw h... alive on ....., 19..., and that death occurred, on the date stated above, at 12:50 p.m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Chronic Myocarditis
136 Mos (duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (SECONDARY) .....
(duration) ...yrs. ...mos. ...ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH?.....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
Sept. 21 1927 (Signed) D. Nice, M. D.
(Address) Everton

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Mo. Crematory — DATE OF BURIAL 9-22-1927

20. UNDERTAKER Morlan-Frem Mo. Av — ADDRESS 1631

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.