

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

Do not use this space.

23962

1. PLACE OF DEATH

County Stoddard
Township Clark
City (No. _____)

Registration District No. 839
Primary Registration District No. 6100

File No. _____
Registered No. 29
St. _____ Ward)

2. FULL NAME

Dollie R. Norman
(a) Residence. No. _____ St. _____ 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 <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Married</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>John H. Norman</u>				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>1881-6-15</u>				
7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>50</u>	<u>no</u>	<u>15</u>	
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work. <u>Home work 7:35</u> (b) General nature of industry, business, or establishment in which employed (or employer). (c) Name of employer				
9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Illinois</u>				
PARENTS	10. NAME OF FATHER <u>Atha Buchanan</u>			
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>U.S.A.</u>			
	12. MAIDEN NAME OF MOTHER <u>Angeline Vaughn</u>			
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>U.S.A.</u>			
14. INFORMANT. <u>Dolan B. Ray</u> (Address) <u>side mo</u>				
15. FILED <u>7-1-31</u> <u>J. P. Brandon</u> REGISTRAR				

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 30 1931
17. I HEREBY CERTIFY, That I attended deceased from June 1, 1931, to _____, 1931, (that I last saw her _____ alive on June 11, 1931, and that death occurred, on the date stated above, at 11:25 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

myocarditis
18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH _____
CONTRIBUTORY (SECONDARY) 950 (duration) _____ yrs. _____ mos. _____ ds.
1930 (duration) _____ yrs. _____ mos. _____ ds.

19. DID AN OPERATION PRECEDE DEATH? No DATE OF _____
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS clinical
(Signed) Testosterone, M. D.
. 19 (Address) Parsons, Mo.

*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 DATE OF BURIAL
Dexter (adler chopped) 6/30/31
20. UNDERTAKER ADDRESS
T. C. Knight Warrens

WRITE PLAINLY, WITH UNFADING INK--THIS IS 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.

JUL 6 8 1931

