

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

35517

Do not use this space.

1. PLACE OF DEATH

(a) County Burkhead Registration District No. 85
 (b) Township St Joseph Primary Registration District No. 1001
 or St Joseph (d) Street No. 108 No 2 St St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

Registered No. 1035

2. PRINT FULL NAME

(a) Residence, No. 108 No 2 St St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Viola Norris

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 1-9-1870

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
69 9 1

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. laborer
 9. Industry or business in which work was done, as saw mill, bank, etc. Day work
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana

FATHER 13. NAME Frank Norris

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana

MOTHER 15. MAIDEN NAME Unknown

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT (ADDRESS) Joseph W. Orady
2217 No 3 St

18. BURIAL, CREMATION, OR REMOVAL PLACE Crem. DATE 10/10/39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) St Joseph No
St Joseph No

20. FILED Oct 17 1939 H. Stettin
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10/10, 1939

22. I HEREBY CERTIFY, That I attended deceased from July 14, 1939, to Oct 6, 1939
 Last saw him/her alive on Oct 6, 1939. Death is said to have occurred on the date stated above, at 3.9 m.
 The principal cause of death and related causes of importance were as follows:

Cardiac Insufficiency Date of onset _____

Other contributory causes of importance: arteriosclerosis 3 yrs
cold & bronchitis 3 days

Name of operation _____ Date of _____
 What test confirmed diagnosis? Clinical (Were an autopsy?) No

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19_____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No
 If so, specify _____
Charles B. Kerner M. D.
 (Address) 221 Kirkpatrick Bldg

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

V. S. NO. 2.
 50M-9-19-38
 I X 16603

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.

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 *J. P. [Signature]*
Licensed Embalmer No. *1946*
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.