

17490

2017

State File No.

Registrar's No.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

1002

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

399

Primary Registration District No.

Registration District No.

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
4150 East 43rd Street 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution NO (Specify whether
In this community Unknown
years, months or days)

3. (a) PRINT FULL NAME Mrs. Ellen C. Norman 1.553. (b) If veteran, name war no 3. (c) Social Security No. NO4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed6. (b) Name of husband or wife Chris T. Norman 6. (c) Age of husband or wife if alive dec years7. Birth date of deceased May 20 1859
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day
80 11 22 hr. min.9. Birthplace Norway
(City, town, or county) (State or foreign country)10. Usual occupation at home11. Industry or business X 712. Name Unknown13. Birthplace Norway
(City, town, or county) (State or foreign country)14. Maiden name Unknown15. Birthplace Norway
(City, town, or county) (State or foreign country)16. (a) Informant Tobias Norman(b) Address 4150 East 43rd St., Kansas City17. (a) Burial (b) Date thereof 5-5-40
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Forest Hill Cemetery18. (a) Signature of funeral director Stine & McClure(b) Address 3235 Gillham Plaza, K. C., Mo.19. (a) May 15, 1940 (b) M. M. Cozme
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits write "RURAL")
(d) Street No. 4150 East 43rd St.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 60 years years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 12th
year 1940 hour 11:00 minute P. M.21. I hereby certify that I attended the deceased from _____, 19____
to _____, 19____that I was physically alive on _____, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to Hodgkins - carcinoma

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)Major findings: _____
Of operations _____

Of autopsy _____

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? _____

While at work? _____
(Specify type of place) (Specify cause of injury)23. Signature M. M. Cozme (M. D. or other) _____Address K.C. Mo. Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

MAY JUN 17 1940

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.....

Dewey Tammes Jr....., Registered Apprentice No. *222*
working under my personal supervision.

Signed *[Signature]*.....
Licensed Embalmer No. *1415*

P. O. Address *K. C. Mo*

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No.

Registration District No.

Primary Registration District No.

Registrar's No. 2017

1. PLACE OF DEATH:

(a) County.....
(b) City or town.....
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
4150 E. 43rd St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
(Specify whether
In this community.....
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....
(c) City or town.....
(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.

3. (a) PRINT FULL NAME Mrs. Ellen C. Norman

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

4. Sex Female 5. Color or White 6. (a) Single, widowed, married, divorced.....

6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... year

7. Birth date of deceased..... (Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month May day 21th year 1940 hour .. minute .. M.

21. I hereby certify that I attended the deceased from .. to .. 19..; that I last saw him .. and that death occurred on the date and hour stated above. Immediate cause of death ..

Chronic form of leukemia involving lungs, spleen & lymph nodes H.H.D.

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?

While at work? (e) Means of injury.....
23. Signature M. M. Browne (M. D. or other).....
Address H. C. M... Date signed.....

Confirmation of diagnosis of death
(a) Signature of funeral director.....
(b) Address.....
(c) Place: burial or cremation.....
18. (a) Signature of funeral director.....
(b) Address.....
19. (a) May 15 1940 M. M. Browne (Date received local registrar) (Registrar's signature)

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

2

S-17490