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KZ3159

NOV 12 1940
Registration District No. 1002

Primary Registration District No. 1002

Registrar's No.

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(c) Name of hospital or institution:
Trinity Lutheran Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 57 years
years, months or days)

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")
0
(d) Street No. Salem Home
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 58 years.

3. (a) PRINT FULL NAME Charles G. W. Norman

3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife Betty Norman 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased April 4 1846
(Month) (Day) (Year)

8. AGE: Years 94 Months 6 Days 23 If less than one day
hr. _____ min.

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

10. Usual occupation Retired Machinist

11. Industry or business _____

MOTHER FATHER { 12. Name Don't know
13. Birthplace Sweden
(City, town, or county) (State or foreign country)
14. Maiden name Don't know
15. Birthplace Sweden
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. Gustaf Norman

(b) Address 99th & Locust

17. (a) Burial (b) Date thereof 10-29-40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Elmwood

18. (a) Signature of funeral director Freeman Mortuary

(b) Address 104 West 42nd Street

19. (a) 10-28-40 (b) M. M. Brome
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 27th
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from Oct. 20
1940 to Oct. 27, 19 40
that I last saw him alive on Oct. 26, 19 40
and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic Pneuonia
Due to age

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? _____ (d) Means of injury _____
23. Signature J. R. Hoal (M. D. or other)
Address 626 1/2 Athol Date signed 10.28.40

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

111 B

Dr. Hall
Funeral Home
Hours from 1:00 to 4:00

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

Clarend W. Childs

Licensed Embalmer No.

3473

P. O. Address

76 E 760

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, fact should be so stated above.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. ?

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 4127

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:.....
(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)

3. (a) PRINT FULL NAME Charles G. W. Norman

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

4. Sex Male 5. Color or race Wh 6. (a) Single, widowed, married, divorced widowed
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)

8. AGE: Years Months Days If less than one day..... min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 12. Name.....

13. Birthplace..... (City, town, or county) (State or foreign country)

14. Maiden name.....

15. Birthplace..... (City, town, or county) (State or foreign country)

16. (a) Informant..... (b) Address.....

17. (a) (Burial, cremation, or removal)..... (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) 10/28/40 (b) M. M. Crowe (Date received local registrar) (Registrar's signature)

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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... day..... year..... hour..... minute..... M.

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

Immediate cause of death Hypostatic pneumonia
No further diagnosis.

Due to..... age
Due to..... 11/6

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?..... (Specify type of place)

(e) Means of injury.....

23. Signature..... (M. D. or other).....

Address..... Date signed.....

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

SUPPLEMENTARY

S-34611