No. 2
1-10-39
17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 12 1940

Registration District No.

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

34623

State File No. 4139

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: ----- 2

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether

In this community About 35 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. 3923 Highland (If rural, give location)

(e) If foreign born, how long in U. S. A.? - years.

3. (a) PRINT FULL NAME Carl Johan Norquist

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 sing

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Jan. (Month) 23, (Day) 1873 (Year)

8. AGE: Years 67 Months 9 Days 6 If less than one day hr. min.

9. Birthplace Kansas (City, town, or county) (State or foreign country) 1

10. Usual occupation Invalid for 30 years 7

11. Industry or business

FATHER
12. Name Peter Norquist 7
13. Birthplace Sweeden (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Christine Peterson
15. Birthplace Sweeden (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Anna Sweedburg

(b) Address 3923 Highland K. C. Mo

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof October 30 (Month) (Day) (Year)

(c) Place: burial or cremation Lindsborg, Kansas

18. (a) Signature of funeral director R.V.LINDSEY & SONS

(b) Address #811 Broadway K. C. Mo.

19. (a) 10-29-40 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 29 year 1940 hour 4 minute 50 P M.

21. I hereby certify that I attended the deceased from Oct. 18, 1940 to Oct 29, 1940; that I last saw him alive on Oct 28, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Broncho-pneumonia	1 day
Due to —	
10 Ta	
Due to —	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations None

Of autopsy None

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? (e) Means of injury

23. Signature Kenneth G. Davis M.D. (M. D. or other)

Address 330 Woodland Date signed 10-29-40

(Licensed Embalmer's Statement on Reverse Side)

Dr. Kenneth Davis
3228 Euclid

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 _____

Licensed Embalmer No. 3738

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.