

No. 2
1-10-39
17-39
X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **37894**
Registration District No. **399**
County Registration District No. **1002**
Registrar's No. **4492**

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

FILED DEC 11 1940

1. PLACE OF DEATH:
Jackson
(a) County Kansas City
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 4316 Genesee
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution About 20 years (Specify whether years, months or days)

8. (a) PRINT FULL NAME Mrs. Grace Norman
3. (b) If veteran, name war - 3. (c) Social Security No. -

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife David Oliver Norman 6. (c) Age of husband or wife if alive 1879 years
7. Birth date of deceased Oct. 17 1879
(Month) (Day) (Year)

8. AGE: Years 61 Months 1 Days 7 If less than one day hr. min.

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

10. Usual occupation At Home

11. Industry or business
MOTHER FATHER { 12. Name James Smith
13. Birthplace New York
(City, town, or county) (State or foreign country)
14. Maiden name Serepta Slaughter
15. Birthplace Ohio
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. J. S. Henry
(b) Address 1717 Westport Road

17. (a) Removal (b) Date thereof 11-26-40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Unionville, Mo

18. (a) Signature of funeral director R. V. Lindsey & Sons
(b) Address 3811 Broadway

19. (a) 11-25-40 (b) M. M. Brown
(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. 4316 Genesee (If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Nov. day 24th
year 1940 hour 4:35 PM minute _____ M.
21. I hereby certify that I attended the deceased from 11/24/40
_____ 19 _____ to 11/24/40 19 _____
that I last saw her alive on 11/24/40 19 _____
and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral Hemorrhage
Due to: Hypertension
Due to: Atherosclerosis
Other conditions: _____
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: _____
Of operations: _____
Of autopsy: _____
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) (f) Means of injury _____
23. Signature Edgar C. ... (M. D. or other) _____
Address Alaya Medical Bldg. Date signed 11/25/40

M. Carver
Plaza Medicines Bldg
1130 - 5

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.....

Edison H. Peters

Registered Apprentice No. *271*

working under my personal supervision.

Signed *Joseph Wheeler*

Licensed Embalmer No. *3738*

P. O. Address *W.C. 245*

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.