

S. No. 2  
-11-10-39  
5-17-39  
I X21492

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

51  
State File No. **9455**  
Registrar's No. **864**

Registration District No. **399**

Primary Registration District No. **1002**

**1. PLACE OF DEATH:**  
(a) County **Jackson**  
(b) City or town **Kansas City**  
(c) Name of hospital or institution: **St. Joseph Hospital**  
(d) Length of stay: **1 month**  
In this community **25 years**

**2. USUAL RESIDENCE OF DECEASED:**  
(a) State **Missouri** (b) County **Jackson**  
(c) City or town **Kansas City**  
(d) Street No. **4003 Prospect**  
(e) If foreign born, how long in U. S. A.? **0** years.

3. (a) PRINT FULL NAME **Victor Carl Norstrom**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **268-10-0372**

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

6. (b) Name of husband or wife **Dorothy V. Norstrom** 6. (c) Age of husband or wife if alive **41** years

7. Birth date of deceased **October 28 1886**

8. AGE: Years **54** Months **3** Days **29** If less than one day hr. min.

9. Birthplace **Williamsburg / Kansas**

10. Usual occupation **Salesman**

11. Industry or business **Cosmetics**

12. Name **Peter O. Norstrom** 18. Birthplace **Sweden**

14. Maiden name **No Record** 15. Birthplace **Sweden**

16. (a) Informant **Mrs. Dorothy V. Norstrom**  
(b) Address **4003 Prospect**

17. (a) Burial **Burial** (b) Date thereof **2-3-41**

18. (a) Signature of funeral director **J. M. Wagner**  
(b) Address **Kansas City, Mo.**

19. (a) **3/1/41** (b) **M. M. Brown**

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month **Feb.** day **27**  
year **1941** hour **4** minute **00** P. M.

21. I hereby certify that I attended the deceased from **Jan 26-41**  
to **Feb 27 1941**  
that I last saw him alive on **Feb 27 1941**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Multiple Sclerosis**  
Due to **fall** (Spinal cord)  
Due to **fall**

Other conditions (Include pregnancy within 3 months of death) **180 lb**

Major findings: Of operations **18**  
Of autopsy

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) **1 yr fall**  
(b) Date of occurrence  
(c) Where did injury occur? **Hrs Home**  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
While at work? **Home**  
23. Signature **Dr. John D. ...**  
Address **1409 Bryant**

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

838

C

4559

**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 A. R. Haunschild

Licensed Embalmer No. 4159

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.**