

FILED MAY 6 1943/49  
Registration District No.

Primary Registration District No. 1002

Registrar's No.

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

1. PLACE OF DEATH:  
(a) County Jackson County  
(b) City or town Kansas City, Mo  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Mercy Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 8 hours 15 min  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED: 48  
(a) State Missouri (b) County Jackson  
(c) City or town Buckner, Mo R#1  
(If outside city or town limits, write "RURAL")  
(d) Street No. R#1 (If rural, give location)  
(e) Citizen of foreign country? (Yes or No) 1  
If yes, name country

3. (a) PRINT FULL NAME Norma Marie Cross

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

4. Sex f 5. Color or race w. 6. (a) Single, widowed, married, divorced single

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

7. Birth date of deceased March 11, 1939  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
4 1 10 hr. min.

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

10. Usual occupation child

11. Industry or business

12. Name Clara C. Cross

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

14. Maiden name Lilly May Day

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

16. (a) Informant Mercy Hosp.

(b) Address K.C. Mo.

17. (a) Removed (b) Date thereof 4-23-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Buckner Mo.

18. (a) Signature of funeral director Selbeter

(b) Address K.C. Mo.

19. (a) 4-28-43 (b) M. M. Cross  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 21  
year 1943 hour 6 minute 35 M.  
21. I hereby certify that I attended the deceased from April 21  
1943 to April 21 1943  
that I last saw him alive on \_\_\_\_\_ 19\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death: Post mortem  
1. Atelectasis  
Due to 2. Myocardial Infarction  
3. lungs 1943  
Due to 3. Myocardial Infarction  
Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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)  
(g) Means of injury D  
23. Signature John H. Haskins (M. D. or other)  
Address Mercy Hospital Date signed 4-21-43

*Handwritten marks*

---

---

**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.....

P. O. Address.....

**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.**