

FILED DEC 6 1943
Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 1225

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Missouri Methodist Hospital
(If not in hospital or institution, write street number or location) 0
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 48 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan 011
(c) City or town St. Joseph 1
(If outside city or town limits, write "RURAL") 7
(d) Street No. 906 South 9th St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME William Norris

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

4. Sex Male 0
5. Color or race White 0
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 June 10, 1870
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
73 4 17 hr. _____ min.

9. Birthplace De Kalb, Illinois 1
(City, town, or county) (State or foreign country)

10. Usual occupation Laborer (Not employed)

11. Industry or business Last worked for Burlington R.

MOTHER FATHER {
12. Name Unknown
13. Birthplace Unknown 6
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant Social Welfare Records

(b) Address St. Joseph, Mo.

17. (a) Burial (b) Date thereof Oct. 28, 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place of burial or cremation City Cemetery
605 E. King Wal Ave.

18. (a) Signature of funeral director [Signature]
(b) Address _____

19. (a) Oct. 28, 1943 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 27
year 1943 hour 3 minute 15P M.

21. I hereby certify that I attended the deceased from
October 9 19 43, October 27 19 43
that I last saw him alive on October 27 19 43;
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Cardiac vascular disease 4 yrs.
Aortic regurgitation
Due to Arteriosclerosis general
Senility 4 yrs.
Due to _____

Other conditions _____
(Include pregnancy within 3 months of death) 938

R. _____ 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)
(e) Means of injury _____
23. Signature [Signature] M. D. or other _____ M. D.
Social Welfare Board 10/28/43
Address _____ Date signed _____

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

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..... *Emuel Clark*

Licensed Embalmer No. *4238*

P. O. Address *St Joseph 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, fact should be so stated above.