

FILED OCT 13 1944

Registration District No. 324

Primary Registration District No. 6093

Registrar's No. 163

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

1. PLACE OF DEATH:

(a) County Saline  
(b) City or town Marshall, Mo.  
(c) Name of hospital or institution:  
Mo State School Marshall, Mo.  
(d) Length of stay: In hospital or institution. 2  
In this community 2 years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Saline  
(c) City or town Marshall, Mo.  
(d) Street No. ....  
(e) Citizen of foreign country? no.

3. (a) PRINT FULL NAME Norman Thomas Gross

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced —

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

7. Birth date of deceased. Aug. 13 1926  
(Month) (Day) (Year)

8. AGE: Years 18 Months 1 Days 0 If less than one day hr. min.

9. Birthplace Talala Pgm Co. Oklahoma (State or foreign country)

10. Usual occupation .....

11. Industry or business .....

MOTHER FATHER { 12. Name James G. Gross  
13. Birthplace St. Charles, Mo  
14. Maiden name May Stanbery  
15. Birthplace Richie, Mo

16. (a) Informant Mo. State School Records

(b) Address Yearsboro, Mo.

17. (a) Removal (b) Date thereof 9-13-1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Autopsy, Mo

18. (a) Signature of funeral director J. Paul Murray  
(b) Address Marshall, Mo

19. (a) 9-13-44 (b) Mo. T. Westbrook  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept, day 13, year 1944 hour 11 minute 9 M.

21. I hereby certify that I attended the deceased from investigated Sept 13 1944 that I last saw h. alive on 19 and that death occurred on the date and hour stated above.

Immediate cause of death Accidental drowning  
Due to State School Lake

Due to subject to epilepsy attacks  
Other conditions 18313  
(Include pregnancy within 3 months of death)

Major findings: Of operations 18313  
Of autopsy no

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) Accidental  
(b) Date of occurrence Sept 13, 1944  
(c) Where did injury occur? Mo. State School Lake  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

(Specify type of place) While at work? (c) Means of injury

23. Signature P. L. Lawless (M. D. or other) Croner Saline Co  
Address Marshall Mo Date signed 9.13.44

PHYSICIAN  
Underline the cause to which death should be charged statistically.

RECEIVED  
District Health Officer No. 8,  
District File Number \_\_\_\_\_  
Date Filed 10-12-44

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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.....

*Reily Taylor*

Licensed Embalmer No. 3237

P. O. Address.....

*Marshall M.*

**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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ect  
Registrar's No. 163

Registration District No. 324

Primary Registration District No. 6093

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

1. PLACE OF DEATH:

(a) County Saline

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

(c) Name of hospital or institution: Mo. State School  
(If not in hospital or institution, write street number or location)

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

In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME Norman J. Chase

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex m

5. Color or race w

6. (a) Single, widowed, married, divorced 3

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased: aug 13 1883  
(Month) (Day) (Year)

8. AGE: Years 18 Months \_\_\_\_\_ Days \_\_\_\_\_  
If less than one day \_\_\_\_\_ min.

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

10. Usual occupation Student

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 9-13-44 (b) Ms T. DeSelle  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_

(c) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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? \_\_\_\_\_

While at work? \_\_\_\_\_  
(Specify type of place)

(e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

Supplementary

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