

FILED MAR 15 1945

Registration District No. ~~445~~ Primary Registration District No. ~~445~~ 4455 Registrar's No. 1

1. PLACE OF DEATH:

(a) County St. Charles

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

(c) Name of hospital or institution:  
Postage Des. Sisy. Mo.  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community Seven Months  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Charles

(c) City or town St. Charles County  
(If outside city or town limits, write "RURAL")

(d) Street No. Postage Des. Sisy. Mo.  
(If rural, give location)

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

3. (a) PRINT FULL NAME EMILY - NORMAN

3. (b) If veteran, name war No

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 31  
year 1945 hour 8 minute A M.

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife Samuel Norman

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

7. Birth date of deceased March 2 1858  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Jan 26  
1945 to Jan 31 1945;  
that I last saw her alive on Jan 31 1945;  
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>86</u>	<u>10</u>	<u>29</u>	hr. _____ min. _____

Immediate cause of death Chronic Myocarditis 3 year

9. Birthplace St. Charles Co., Mo. (City, town, or county) (State or foreign country)

Due to Chronic Hepatitis 10 years

10. Usual occupation Housewife

Other conditions Gen. Arterio Sclerosis 12 years

MOTHER FATHER

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

12. Name John Rogers

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

14. Maiden name Mary McMill

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

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy 1316

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

16. (a) Informant Elnor Halzeman

(b) Address Postage Des. Sisy. Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 3 1945  
(Month) (Day) (Year)

(c) Place: burial or cremation St. Francis Lem. Postage Des. Sisy. Mo.

18. (a) Signature of funeral director H.C. Dallmeyer

(b) Address 201 N. Second St. Charles, Mo.

19. (a) Feb. 14, 1945 (Date received local registrar) Rose Barnard (Registrar's signature)

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? \_\_\_\_\_

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

23. Signature C.A. Barnard (M. D. or other) Feb 4  
Address Postage Des. Sisy. Mo. Date signed Jan 4 1945

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

200

RECEIVED

District Health Officer No.

District File Number

Date Filed 3-14-45

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

*John E. Hallmeyer*

Licensed Embalmer No. 2951

P. O. Address

*St Charles 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.**