

FILED FEB 11 1946

Registration District No. 155 Primary Registration District No. 5580 Registrar's No. 1

1. PLACE OF DEATH:

(a) County Jasper

(b) City or town rural - Twin Grove Twnshp  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
Carl Junction, Route 1  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 38 years (Specify whether years, months or days)

In this community \_\_\_\_\_

3. (a) PRINT FULL NAME Mamie Austin Norton

3. (b) If veteran, name war none

3. (c) Social Security No. none

4. Sex female 5. Color or race white

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

6. (b) Name of husband or wife Dr. R. A. Norton 6. (c) Age of husband or wife if alive 74 years

7. Birth date of deceased October 2 1876  
(Month) (Day) (Year)

8. AGE: Years 69 Months 2 Days 28 If less than one day hr. min.

9. Birthplace Ralls County Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation at home

11. Industry or business -----

MOTHER FATHER { 12. Name Thomas Hart

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

14. Maiden name Hettie Rosser

15. Birthplace Ralls County Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Dr. R. A. Norton

(b) Address Carl Junction, Route 1

17. (a) burial (b) Date thereof Jan 2, 1946  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Park Cemetery

18. (a) Signature of funeral director Knell Mortuary

(b) Address Carthage Mo.

19. (a) JAN 23 46 (b) W. D. Hogan  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper 49

(c) City or town rural; TWIN GROVE TWP.  
(If outside city or town limits, write "RURAL") 0

(d) Street No. Carl Junction, Route 1  
(If rural, give location) 0

(e) Citizen of foreign country? No (Yes or No)

If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 30 year 1945 hour 5:05 minute P M.

21. I hereby certify that I attended the deceased from May 1945 to Dec 30 1945; that I last saw her alive on Dec 30 1945; and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of l. lung 32 Duration

Due to operation of l. breast 3 yrs

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

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

Major findings: Of operations W.D.

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 W. D. Hogan (M. D. or other) MD  
Address Neak City, Mo. Date signed 12/31/45

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

100504

99  
0  
0

187

46-1-4

7/26 12 1947  
7/26 12 1947

AUG 1 1947

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.....

*Frank W. Kuehl Jr.*

....., Registered Apprentice No. *379*

working under my personal supervision.

Signed.....  
*Emm L. Truel*

Licensed Embalmer No. *391*

P. O. Address.....  
*Carlsberg*

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.