

**FILED DEC 17 1946**

Registration District No. **59**

Primary Registration District No. **4097**

Registrar's No. **176**

**1. PLACE OF DEATH:**

(a) County **Case**  
(b) City or town **Harrisonville**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **Memorial**  
(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

**2. USUAL RESIDENCE OF DECEASED:**

(a) State **MO** (b) County **Case**  
(c) City or town **Pleasant Hill**  
(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 \_\_\_\_\_

**3. (a) PRINT FULL NAME** **Don Sevill Norman**

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

4. Sex **male** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **0**

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

7. Birth date of deceased **Dec 2 1946**  
(Month) (Day) (Year)

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

9. Birthplace **Harrisonville Mo.**  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

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

MOTHER FATHER

12. Name **James S. Norman**

13. Birthplace **Clay Co. Mo.**  
(City, town, or county) (State or foreign country)

14. Maiden name **Vivah I. Simpson**

15. Birthplace **Gower Mo.**  
(City, town, or county) (State or foreign country)

16. (a) Informant **James S. Simpson**

(b) Address **Pleasant Hill, Mo.**

17. (a) **Burial** (b) Date thereof **12-5-46**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Ridgeway, Mo.**

18. (a) Signature of funeral director **Allen Brownfield**  
(b) Address **Pleasant Hill, Mo.**

19. (a) **12-9-1946** **Laura J. Jones**  
(Date received local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month **Dec 2** day **1946** -  
year **11** hour **45** minute **H** M.

21. I hereby certify that I attended the deceased from **10:45 AM**  
**2 Dec 1946** to **11:45 AM 2 Dec 1946**  
that I last saw him alive on **2 Dec 1946**, 19\_\_\_\_, and that death occurred on the date and hour stated above.

Immediate cause of death **Asphyxia Neonatorum -**  
**1. Maternal Low Grade Toxemia**  
Due to **2. Contracted Outlet, Pelvis**  
**3. Extended 2d Stage Labor (4 hrs)**  
Due to **4. Extreme Moulding of Head**  
**5. Dystocia - 36 year old -**  
Other conditions **Primipara**  
(Include pregnancy within 3 months of death)

Duration

PHYSICIAN

Major findings:  
1 Of operations \_\_\_\_\_  
Of autopsy **Carver Cass County**  
**Fat Not Needed**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: **None**

(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 **Clifford W. Eklund** (M. D. or other) **M.D.**

Address **129 First St. Pleasant Hill, Mo.** Date signed **12-2-46**

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.....

*W.D. Embalsmed*....., Registered Apprentice No.....  
working under my personal supervision.

Signed..... *Allen Brunker*.....

Licensed Embalmer No. *3185*

P. O. Address..... *Denial Hill*.....

**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.**

Registration District No. 59

Primary Registration District No. 4097

1. PLACE OF DEATH:

(a) County Cass  
(b) City or town Harrisonville  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(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 (Specify whether \_\_\_\_\_)

3. (a) PRINT FULL NAME Don S. Norman

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 s

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

7. Birth date of deceased Dec 2 (Month) 1946 (Day) 1946 (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one year, \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

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

MOTHER FATHER { 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 \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)  
(c) Place: burial or cremation \_\_\_\_\_

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

19. (a) \_\_\_\_\_ (b) Rana Jones (Registrar's signature)  
(Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) County Cass State Missouri  
(b) City or town Pleasant Hill, Mo  
(If outside city or town limits, write "RURAL")  
(c) Street No. \_\_\_\_\_ (If rural, give location)  
(d) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec 1946 year. \_\_\_\_\_ hour. \_\_\_\_\_ minute. \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 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 \_\_\_\_\_

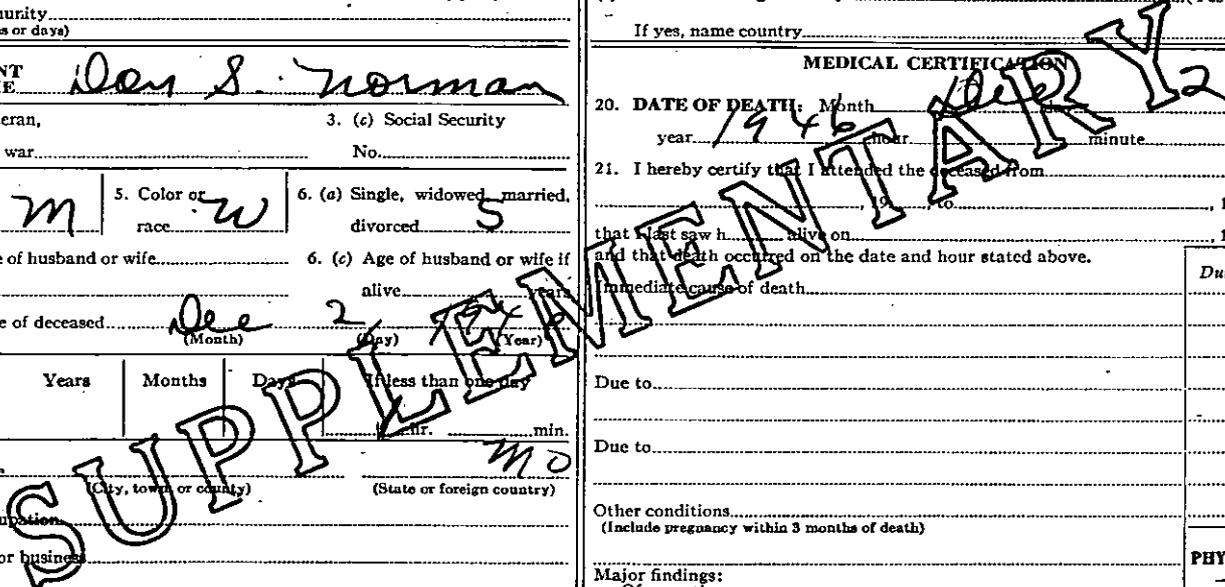
PHYSICIAN  
Underline the cause to which death should be charged statistically.

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) (c) Means of injury \_\_\_\_\_

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



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

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