

FILED SEP 25 1947

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 31691

Registration District No. 170

Primary Registration District No. 2032

Registrar's No.

1. PLACE OF DEATH:

(a) County Laclede  
(b) City or town Lebanon  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Wallace Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 6 hrs  
In this community always (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Laclede  
(c) City or town Lebanon  
(If outside city or town limits, write "RURAL")  
(d) Street No. 401 Harrison  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Norma Louise SARACINO

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

4. Sex F / 5. Color or race W 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 Sept. 2 1947  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
6 hr. 25 min.

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

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

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

12. Name Joseph P. Saracino

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

14. Maiden name Norma Brown

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

16. (a) Informant Joseph P. Saracino

(b) Address Lebanon, Mo.

17. (a) burial (b) Date thereof 9/3/47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lebanon

18. (a) Signature of funeral director Palmer's

(b) Address Lebanon, Mo.

19. (a) Sept 13, 1947 (b) Rev. Frank Berger  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 2  
year 1947 hour 4 minute 15 A.M.

21. I hereby certify that I attended the deceased from 9:30 pm  
Sept. 2, 1947, to 4:15 A.M. Sept. 3, 1947,  
that I last saw her alive on Sept. 3, 1947,  
and that death occurred on the date and hour stated above.

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

Breach Delivery  
Due to Premature Delivery

Due to Frequency 6 1/2 mo

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

Major findings: \_\_\_\_\_  
Of operations 159

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 i

23. Signature Paul J. ... (M. D. or other) \_\_\_\_\_

Address Lebanon, Mo. Date signed 9-13-47

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

Received ..... 9/23/47 .....  
Laclede County Health Unit  
File No. 9-47-151 .....  
Date Filed ..... 9/23/47 .....

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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.

*Not embalmed*

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**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.