

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

25079

State File No. 5759

FILED JUL 16 1951

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Illinois b. COUNTY Williamson	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS, MO.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural-West Marion 8120	
c. LENGTH OF STAY (in this place) 5 days		d. STREET ADDRESS (If rural, give location) Rd. Dist. 9-2	
d. FULL NAME OF HOSPITAL OR INSTITUTION BARNES HOSPITAL			
3. NAME OF DECEASED (Type or Print) a. (First) Rachel b. (Middle) Evelyn c. (Last) Norris		4. DATE OF DEATH (Month) (Day) (Year) June 23, 1951	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Oct. 27, 1902
9. AGE (In years last birthday) 48		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (State or foreign country) Illinois
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY? U.S.
13a. FATHER'S NAME William McCluckie		13b. MOTHER'S MAIDEN NAME Margaret Patterson	14. NAME OF HUSBAND OR WIFE O.L. Norris
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME ADDRESS O.L. Norris, Marion, Ill.
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Increased Intracranial Pressure ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Carcinoma of Unknown Site DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>	
19a. DATE OF OPERATION June 21, 1951		19b. MAJOR FINDINGS OF OPERATION Metastatic Carcinoma of Brain	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 193X
22. I hereby certify that I attended the deceased from June 18, 1951 , to June 23, 1951 , that I last saw the deceased alive on JUNE 23, 1951 , and that death occurred at 6:15 p.m., June 23, 1951 , from the causes and on the date stated above.			
23a. SIGNATURE J. Schreiber, M.D. (Degree or Title)		23b. ADDRESS BARNES HOSPITAL	23c. DATE SIGNED
24a. BURIAL CREMATION REMOVAL (Specify)	24b. DATE 6-24-51	24c. NAME OF CEMETERY OR CREMATORY New Rose Hill	24d. LOCATION (City, town, or county) (State) Marion, Ill.
DATE REC'D BY LOCAL REG. JUN 26 1951		REGISTRAR'S SIGNATURE J. B. Raster	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe, 4700 Washington Blvd.

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 me

.....
working under my personal supervision.

Student Embalmer No.

Signed [Signature]

Signed.....
Student Embalmer

Licensed Embalmer No. 4699

P. O. Address [Signature]

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.