

No. 300
10. 48

FILED JUN 9 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 16103

BIRTH NO. _____ REG. DIST. NO. 12c PRIMARY REG. DIST. NO. 2000 Registrar's No. 544

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WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Mo. b. COUNTY Laclede	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield	c. LENGTH OF STAY (In this place)	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Conway	1530
d. FULL NAME OF HOSPITAL OR INSTITUTION Springfield Baptist Hospital		d. STREET ADDRESS (If rural, give location) 1	

3. NAME OF DECEASED (Type or Print)	a. (First) MAY	b. (Middle)	c. (Last) NORTON	4. DATE OF DEATH (Month) (Day) (Year) June 3 1952
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5. SEX F	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Feb 9, 1871	9. AGE (In years) (Months) (Days) 81	IF UNDER 1 YEAR	IF UNDER 6 HRS.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Conway Mo	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Jacob J. Miller	13b. MOTHER'S MAIDEN NAME Mary Ellen Schmalkorst	14. NAME OF HUSBAND OR WIFE ---
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. No	17. INFORMANT'S SIGNATURE OR NAME Bertha Miller, sister	ADDRESS Conway Mo
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.</i>	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis, Internal Capsule		INTERVAL BETWEEN ONSET AND DEATH 10 days 5 yrs. 5 years.
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerotic Heart Disease		
	DUE TO (c) Parkinson's Disease		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Generalized Arteriosclerosis			

19a. DATE OF OPERATION None	19b. MAJOR FINDINGS OF OPERATION None	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) None	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **AUGUST, 1947**, to **JUNE 3, 1952**, that I last saw the deceased alive on **JUNE 3, 1952**, and that death occurred at **7:55 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE William J. Paul, M.D.	23b. ADDRESS 609 Cherry, Springfield Mo	23c. DATE SIGNED 6/3/52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 6-5-52	24c. NAME OF CEMETERY OR CREMATORY Graceland Cemetery	24d. LOCATION (City, town, or county) (State) Conway Mo.
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DATE REC'D BY LOCAL REG. 6-3-52	REGISTRAR'S SIGNATURE Edith Williamson	25. FUNERAL DIRECTOR'S SIGNATURE W.E. Holman	ADDRESS Lebanon Mo.
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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.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed *Dorsey M. Howe*

Licensed Embalmer No. *4222*

P. O. Address *Lebanon, 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.