

FILED FEB 3 1953

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

3560

State File No. \_\_\_\_\_

318

1003

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BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____		
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY _____				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis, Missouri</b>		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		<b>2229</b>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Louis City Hospital</b>				d. STREET ADDRESS (If rural, give location) <b>22 2325a Hickory</b>				
3. NAME OF DECEASED (Type or Print) <b>THEODORE</b>			a. (First) _____		b. (Middle) _____		c. (Last) <b>NORRIS</b>	
4. DATE OF DEATH <b>JANUARY 22, 1953</b>		(Month) _____ (Day) _____ (Year) _____		5. SEX <b>Male</b>		6. COLOR OR RACE <b>white</b>		
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>Apr. 23, 1894</b>		9. AGE (in years last birthday) <b>58</b>		IF UNDER 1 YEAR: Months <b>8</b> Days <b>29</b> IF UNDER 1 MO. Hours _____ Mins. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13a. FATHER'S NAME <b>William Norris</b>		13b. MOTHER'S MAIDEN NAME <b>Laura Salveter</b>		14. NAME OF HUSBAND OR WIFE <b>Fern Norris</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>988 (link)</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Fern Norris, 2325a Hickory, St. Louis</b>				
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, ashenic, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Pulmonary insufficiency</b>  ANTECEDENT CAUSES <b>Due to (b) Asthma &amp; Bronchitis</b>  Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS <b>Secondary Polycythemia</b> Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH _____		
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <b>Cor Pulmonale</b>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) _____		
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>241X</b>						
22. I hereby certify that I attended the deceased from <b>1-7-53</b> , 19____, to <b>1-22-53</b> , 19____, that I last saw the deceased alive on <b>1-22-53</b> , 19____, and that death occurred at <b>11:40 P.M.</b> , from the causes and on the date stated above.								
23a. SIGNATURE <b>John W. Wallace M.D.</b> (Degree or title) _____				23b. ADDRESS <b>1515 Lafayette Avenue</b>		23c. DATE SIGNED <b>1-23-53</b>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>Jan. 26, 1953</b>		24c. NAME OF CEMETERY OR CREMATORY <b>National Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>Jefferson Brk's., Mo.</b>		
DATE REC'D BY LOCAL REG. <b>JAN 24 1953</b>		REGISTRAR'S SIGNATURE <b>J. Earl Smith, M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>McLaughlin Funeral Home, 2301 Lafayette</b> ADDRESS _____				

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

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 James R. Chapman

Licensed Embalmer No. 4550

P. O. Address St. Louis, 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.