

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

27591

State File No.

BIRTH NO. 40773 REG. DIST. NO. 1 PRIMARY REG. DIST. NO. 3000 Registrar's No. 254

1. PLACE OF DEATH a. COUNTY <u>Adair</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>None</u> b. COUNTY <u>None</u>	
b. CITY (If outside corporate limits, write RURAL and give town) <u>Kirkville</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>None</u>	
c. LENGTH OF STAY (in this place) <u>35 hrs.</u>		d. STREET ADDRESS (If rural, give location) <u>None</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Laughlin Hospital and Clinic</u>		e. CITY <u>None</u> <u>0013</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Baby</u>	b. (Middle) <u>Boy</u>	c. (Last) <u>Norfolk</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>7</u> <u>29</u> <u>53</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never Married</u>	8. DATE OF BIRTH <u>7-28-53</u>
9. AGE (In years last birthday) <u>12</u>	IF UNDER 1 YEAR Months	IF UNDER 4 HRS. Hours Min.	11. BIRTHPLACE (State or foreign country) <u>Missouri</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	10b. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	

13a. FATHER'S NAME <u>Kenneth Dean Norfolk</u>	13b. MOTHER'S MAIDEN NAME <u>Esther Earlene Lawson</u>	14. NAME OF HUSBAND OR WIFE <u>None</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Esther N. Norfolk</u>	ADDRESS <u>Kirkville</u>
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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, asthma, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acrania</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>750X</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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)
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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 July 28, 1953 to July 29, 1953, that I last saw the deceased alive on July 29, 1953, and that death occurred at 10:50 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Thelma Lelback D.O.</u>	23b. ADDRESS <u>Kirkville, Mo</u>	23c. DATE SIGNED <u>7-30-53</u>
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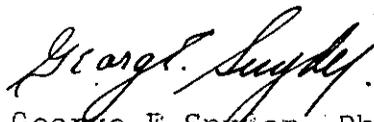
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>PRESERVATION</u>	24b. DATE <u>8-1-53</u>	24c. NAME OF CEMETERY OR CREMATORY <u>KCOS Hospital</u>	24d. LOCATION (City, town, or county) (State) <u>Kirkville Mo</u>
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DATE REC'D BY LOCAL REG. <u>8-1-53</u>	REGISTRAR'S SIGNATURE <u>Wate Lambert</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>H. Snyder</u>	ADDRESS <u>Kirkville Mo</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

This body has been released to the Kirksville College of
osteopathy and Surgery for scientific purposes.



George E Snyder, Ph.D.
Chairman, Division of Anatomy

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 _____

working under my personal supervision.

Student Embalmer No.

Signed _____

Signed
Student Embalmer

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.