

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

State File No. **24171**
Registrar's No. **6365**

BIRTH NO. **60594-55** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY OR TOWN ST. Louis		c. CITY OR TOWN ST. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION LUTHERAN		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or Print) a. (First) THOMAS b. (Middle) - c. (Last) NORWOOD		4. DATE OF DEATH (Month) (Day) (Year) 7-11-55	
5. SEX MALE	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Newborn	8. DATE OF BIRTH 7-11-55
9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (City and State or Foreign Country) ST. Louis Missouri
13a. FATHER'S NAME JAMES EDWARD NORWOOD		13b. MOTHER'S MAIDEN NAME JANE ANN HUDSPETH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME		ADDRESS	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <small>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</small>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 5 hr.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Prematurity (24 wk) & asphyxia E lipi Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) maternal premature rupture of membranes 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	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)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **7/11, 1955**, to **7/11, 1955**, that I last saw the deceased alive on **7/11, 1955**, and that death occurred at **5:00 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE Paul Parole M.D. (Degree or title)	23b. ADDRESS 5203 Olive	23c. DATE SIGNED 7/11/55
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 7-12-55	24c. NAME OF CEMETERY OR CREMATORY MEMORIAL PARK
24d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.	25. FUNERAL DIRECTOR'S SIGNATURE Arthur J. Donnelly ADDRESS 3840 Lindell	
DATE REC'D BY LOCAL REG. JUL 25 1955	REGISTRAR'S SIGNATURE Carl Smith M.D.	

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

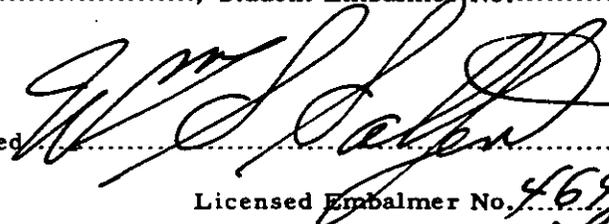
No. 300
10-48

FILED AUG 15 1955

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.....
Signature of Student Embalmer

Signed 

Licensed Embalmer No. 469

P. O. Address 3840 L...

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.