

FILED SEP 19 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 30287

BIRTH NO. _____ REG. DIST. NO. 151 PRIMARY REG. DIST. NO. 3048 Registrar's No. 224

1. PLACE OF DEATH a. COUNTY Nodaway		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Nodaway	
b. CITY OR TOWN Maryville	c. LENGTH OF STAY (in this place) 55 yrs	c. CITY OR TOWN Maryville	d. Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Francis Hospital		f. STREET ADDRESS (If rural, give location) 710 E. 5th	

3. NAME OF DECEASED (Type or Print)	a. (First) James	b. (Middle) P	c. (Last) Norris	4. DATE OF DEATH	(Month) 9	(Day) 5	(Year) 1955
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5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 10-25-1859	9. AGE (In years last birthday) 95	IF UNDER 1 YEAR Months	IF UNDER 1 HRS. Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ret. painter	10b. KIND OF BUSINESS OR INDUSTRY Painting	11. BIRTHPLACE (City and State or Foreign Country) Des Moines, Iowa	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Marshall T. Norris	13b. MOTHER'S MAIDEN NAME Hester Bixley	14. NAME OF HUSBAND OR WIFE Josephine Johnson
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) none	17. INFORMANT'S SIGNATURE OR NAME Mrs. Lula Schoonover-Maryville, M	ADDRESS
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Myocarditis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Atherosclerotic heart disease DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Basal Cell Carcinoma			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)	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 Jan 19 55, to Sep 4, 19 55, that I last saw the deceased alive on 9-4, 1955, and that death occurred at 9 A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) J. E. Dunbar M.D.	23b. ADDRESS Maryville Mo. 710 E. 5th	23c. DATE SIGNED 9-7-1955
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24a. BURIAL CREMATORY (Specify) St. Francis	24b. DATE 9-7-1955	24c. NAME OF CEMETERY OR CREMATORY Miriam emetery	24d. LOCATION (City, town, or county) (State) Maryville, Mo.
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DATE REC'D BY LOCAL REG. 9-11-55	REGISTRAR'S SIGNATURE Bess Holt	25. FUNERAL DIRECTOR'S SIGNATURE W. H. Johnson	ADDRESS Maryville Mo.
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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.....
Signature of Student Embalmer

Signed *G. M. Atchison*.....

Licensed Embalmer No. *22*

P. O. Address *Maryville*

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.