

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

7804
STATE FILE NUMBER

Hendrickson

FILED APR 4 - 1957 Registration District No. 43 Primary Registration District No. 3007 Registrar's No. 252

1. PLACE OF DEATH a. COUNTY <u>Butler</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Shannon</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN. <u>Pohlar Bluff</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Winona</u>		1010 Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Pohlar Bluff</u>			Length of stay in lb <u>5 hrs</u>	d. STREET ADDRESS (If outside, give location) <u>Box 171</u>			Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Arvel</u> Middle <u>Franklin</u> Last <u>Norris</u>				4. DATE OF DEATH Month <u>Mar.</u> Day <u>10</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 13 1948</u>		9. AGE (In years last birthday) <u>8</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>child</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Winona, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>Otis Norris</u>				14. MOTHER'S MAIDEN NAME <u>Arlee Blomd</u>			
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.	17. INFORMANT <u>Leonard Homeycutt</u>			Address <u>Box 171 Winona Mo</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL CONTUSION</u>							INTERVAL BETWEEN ONSET AND DEATH <u>8 HOURS</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>
20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>AUTOMOBILE ACCIDENT</u>				
20c. TIME OF INJURY Hour <u>11 p.m.</u> Month <u>3</u> Day <u>9</u> Year <u>57</u>							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <u>HIGHWAY</u>		20f. CITY, TOWN, OR LOCATION <u>128</u>			COUNTY _____ STATE _____
21. I attended the deceased from <u>3-10-57</u> to <u>3-10-57</u> and last saw her/him alive on <u>3-10-57</u> Death occurred at <u>5 a</u> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>Jesse W. Page, M.D.</u>				22b. ADDRESS <u>Pohlar Bluff, Mo</u>		22c. DATE SIGNED <u>3-20-57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>Mar 11-57</u>	23c. NAME OF CEMETERY OR CREMATOR <u>Eastwood</u>		23d. LOCATION (City, town, or county) (State) <u>Eastwood, Missouri</u>		
24. FUNERAL DIRECTOR ADDRESS <u>Duncan Funeral Home Mtn View Mo</u>			25. DATE RECD. BY LOCAL REG. <u>3/28/57</u>		26. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare, Public Service
300-56
Diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
Doctor, coroner, etc. must use only standard nomenclature in Part I. No symptoms or signs of disease in Part I.

RECEIVED

APR 1 1957
BUTLER CO. HEALTH CENTER

FILE No. _____

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 *Joel R. Seeman* _____
Licensed Embalmer No. *43*
P. O. Address *Mt. View* _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.