

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-023751

FILED VS JUN 30 1960 385

Primary Registration District No. 3039 Registrar's No. 129

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Linn</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Macon</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Marceline</u>		Length of stay in lb <u>6 years</u>	c. CITY OR TOWN <u>New Cambria, Mo.</u>		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>112 East Hauser</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Russell Township</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Clara</u> Last <u>Norfolk</u>			4. DATE OF DEATH Month <u>June</u> Day <u>11</u> Year <u>1960</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>8/18/94</u>	9. AGE (last birthday) <u>65 yrs</u>	IF UNDER 1 YEAR Months <u>9</u> Days <u>23</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own h me</u>	11. BIRTHPLACE (City and state or country) <u>New Cambria, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>
13a. FATHER'S NAME <u>William Dowell</u>		13b. MOTHER'S MAIDEN NAME <u>Malissa Rhodes</u>		14. NAME OF HUSBAND OR WIFE <u>Charles Clift Norfolk</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. <u>no.</u>		17. INFORMANT <u>Mrs. Jean Carlson</u> Address <u>132 East Howe</u> <u>Marceline, Missouri</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>Myocardial Infarction</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Pulmonary Infarction</u> DUE TO (c) <u>Arteriosclerotic Cardiovascular Disease</u>					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Hypertension, Mellitus & Chronic Dehydration.</u>					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input 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.)			
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____	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.)		20f. CITY, TOWN, OR LOCATION		COUNTY	STATE
21. I attended the deceased from <u>1955</u> to <u>1958</u> and last saw her <u>1958</u> alive on <u>1958</u> Death occurred at <u>10:00</u> <u>a</u> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>[Signature]</u> (Degree or title)			22b. ADDRESS <u>Marceline Missouri</u>		22c. DATE SIGNED <u>6-11-60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>JUNE 14, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>NEW CAMBRIA CEMETERY</u>		23d. LOCATION (City, town, or county) <u>NEW CAMBRIA MO.</u>	
24. FUNERAL DIRECTOR <u>[Signature]</u> ADDRESS <u>New Cambria Mo</u>		25. DATE RECD. BY LOCAL REG. <u>6-13-60</u>		26. REGISTRAR'S SIGNATURE <u>Brookie Owens</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed H. P. Gilbert

Licensed Embalmer No. 4019

P. O. Address Mill Creek, Pa.

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