

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-046654

REC 271960
DEB

Registration District No. 164 Primary Registration District No. 3032 Registrar's No. 143

STATE FILE NUMBER

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)				
a. COUNTY <u>Johnson</u>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Warrensburg,</u>		a. STATE <u>Missouri</u> b. COUNTY <u>Johnson</u>		c. CITY OR TOWN <u>Warrensburg,</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>444 E. Gay St.</u>		Length of stay in lb <u>4 months</u>		d. STREET ADDRESS (If outside, give location) <u>444 E. Gay St.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>FLORA</u> Middle <u>E.</u> Last <u>NORMAN</u>				4. DATE OF DEATH Month <u>December</u> Day <u>16th.</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>7-29-78</u>		
9. AGE (last birthday) <u>82</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HR Hours <u> </u> Min. <u> </u>		9. AGE (last birthday) <u>82</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>		11. BIRTHPLACE (City and state or country) <u>Franklin County, Ill.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Lee Edwards</u>			13b. MOTHER'S MAIDEN NAME <u>Clara Kerns,</u>			14. NAME OF HUSBAND OR WIFE <u>Robert E. Norman</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>none</u>		17. INFORMANT Address <u>Mrs. Connie Odel, Warrensburg, Missouri</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Arterio-sclerotic Heart disease</u>							<u>5 years</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) <u>Upper Respiratory tract Infection</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.		Month, Day, Year _____						
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>12-19-60</u> to <u>12-16-1960</u> and last saw <u>him</u> alive on <u>12-16-60</u> Death occurred at <u>9:15 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>M.D.</u>				22b. ADDRESS <u>Warrensburg, Missouri</u>		22c. DATE SIGNED <u>12-18-60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>12-18-1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>KnobNoster Cemetery,</u>		23d. LOCATION (City, town, or county) (State) <u>KnobNoster, Missouri</u>		
24. FUNERAL DIRECTOR ADDRESS <u>The Brauningers, Warrensburg, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>Dec. 18, 1960</u>		26. REGISTRAR'S SIGNATURE <u>Suzannah Cutchfield</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JAN 24 1961

STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

Signed W.A. Bausinger

Licensed Embalmer No. 33

P. O. Address Warrensburg

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