

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

61-021396

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3060

AMENDED

FILED JUL 5 1961

| | | | |
|---|---|--|---|
| 1. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | |
| a. COUNTY Jackson | | a. STATE Missouri b. COUNTY Jackson | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City, Missouri | | c. CITY OR TOWN Kansas City | |
| Length of stay in lb 15 Years | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Trinity-Lutheran Hospital | | d. STREET ADDRESS (If outside, give location) 5842 Bellfontaine | |
| Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | | 4. DATE OF DEATH | |
| First Frankie Middle M. Last Norman | | Month 6 Day 17 Year 61 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 2-24-1913 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker | | 10b. KIND OF BUSINESS OR INDUSTRY | 9. AGE (last birthday) 48 |
| 11. BIRTHPLACE (City and state or country) Clay County, Mo. | | 12. CITIZEN OF WHAT COUNTRY U. S. A. | |
| 13a. FATHER'S NAME B. F. Kanabel | | 13b. MOTHER'S MAIDEN NAME Froncie Cavanaugh | |
| 14. NAME OF HUSBAND OR WIFE Harold O. Norman | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | |
| 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Harold O. Norman Address 5842 Bellfontaine K.C. Mo. | |
| 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) Cardiac insufficiency | | | 12 hours |
| DUE TO (b) acute fulminating meningitis | | | 36 hours |
| DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | | 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 checked="" type="checkbox"/> NO <input 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 Month, Day, Year | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input 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 2-12-47 to 6-17-61 and last saw her alive on 6-16-61 | | | |
| Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE Herbert Shuey, M.D. (Degree or title) | | 22b. ADDRESS 3903 Birchlyn K.C., Mo. | |
| 22c. DATE SIGNED 6-18-61 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 6-19-1961 | 23c. NAME OF CEMETERY OR CREMATORY White Chapel Cemetery | |
| 23d. LOCATION (City, town, or county) Gladstone, Missouri (State) | | | |
| 24. FUNERAL DIRECTOR D.W. Newcomer's Sons North Kansas City ADDRESS | | 25. DATE RECD. BY LOCAL REG. 6-19-61 REGISTRAR'S SIGNATURE Ruth Long | |

DATE AMENDED

INSTEAD OF DOCUMENT

BY AFFIDAVIT OF

SHOULD READ

RECORDS ON THIS RECORD ARE AS FOLLOWS

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

John H. Halebeck

Licensed Embalmer No. 4949

P. O. Address No. Kansas St.

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.