

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **5412**

STATE FILE NUMBER

FILED JUN 16 1961

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY St. Louis | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | Length of stay in lb 3 Weeks | c. CITY OR TOWN Frontenac |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Deaconess Hospital | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) # 11 Outer Ladue Drive |

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|---|--|--|---|--|--|
| 3. NAME OF DECEASED (Type or print) First Edgar Middle Woolfolk Last Norton | | | 4. DATE OF DEATH Month June Day 8 Year 1961 | | |
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|-----------------------|----------------------------------|---|--------------------------------------|-------------------------------------|---|----------------|
| 5. SEX Male | 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 6/23/1899 | 9. AGE (last birthday) 61 | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HR |
|-----------------------|----------------------------------|---|--------------------------------------|-------------------------------------|---|----------------|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Certified Pub. Accountant | 10b. KIND OF BUSINESS OR INDUSTRY Private Business | 11. BIRTHPLACE (City and state or country) Troy, Missouri | 12. CITIZEN OF WHAT COUNTRY U.S.A. |
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| 13a. FATHER'S NAME Elias T. Norton | 13b. MOTHER'S MAIDEN NAME Laura Hudson | 14. NAME OF HUSBAND OR WIFE Lois Balcke Norton |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes W.W.I | 16. SOCIAL SECURITY NO. | 17. INFORMANT Mrs Lois B. Norton # 11 Outer Ladue Drive | Address |
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| 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) Myocardial infarction | | 3 wks |
| DUE TO (b) Coronary arteriosclerotic heart disease ? | | |
| DUE TO (c) 420.1 | | |

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| 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 |
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| 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.) |
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| 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 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 |
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| 21. I attended the deceased from 5-15-61 , to 6-8-61 and last saw her/him alive on 6-8-61 Death occurred at 3:40 p. m on the date stated above, and to the best of my knowledge, from the causes stated. |
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| 22a. SIGNATURE (Degree or title) D.E. McCallan, M.D. | 22b. ADDRESS 634 N. Grand Blvd. | 22c. DATE SIGNED 6-9-61 |
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|--|-----------------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal (Auto) | 23b. DATE June 10, 1961 | 23c. NAME OF CEMETERY OR CREMATORY Lakeside Cemetery | 23d. LOCATION (City, town, or county) (State) Pekin, Illinois |
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| 24. FUNERAL DIRECTOR ADDRESS Alexander & Sons 6175 Delmar Blvd | 25. DATE RECD. BY LOCAL REG. JUN 9 1961 | 26. REGISTRAR'S SIGNATURE Lois Smith, M.D. |
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| BY AFFIDAVIT OF | |
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Dr. Clarence Mueller

Mo. Theatre Bldg

Je. 3-7469

9:30 to 11:30 A.M.

2 to 6 P.M.

expired

expired

X

expired

expired

expired

expired

X

expired

expired

A.A.U.

expired

expired

expired

expired

expired

expired

expired

expired

expired

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 J. Allen Rains

Licensed Embalmer No. 4083

P. O. Address M.L.

June 8-1961

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.