

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-013665

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **2146** STATE FILE NUMBER

FILED MAR 20 1963

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St Louis		a. STATE MO b. COUNTY	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 5266⁹ Page		d. STREET ADDRESS (If outside, give location) 5266⁹ Page	

3. NAME OF DECEASED (Type or print) First Lewis Middle Last NORRIS			4. DATE OF DEATH Month 2 Day 22 Year 63		
5. SEX M	6. COLOR OR RACE NEGRO	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1-21-1908	9. AGE (last birthday) 55	IF UNDER 1 YEAR Months Days

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WASH MAN		10b. KIND OF BUSINESS OR INDUSTRY Laundry		11. BIRTHPLACE (City and state or country) MARIANNA ARK		12. CITIZEN OF WHAT COUNTRY U.S.A	
13a. FATHER'S NAME JOE NORRIS			13b. MOTHER'S MAIDEN NAME ELLA ROBINSON			14. NAME OF HUSBAND OR WIFE MATRIC NORRIS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16. SOCIAL SECURITY NO. NO		17. INFORMANT Address MATRIC NORRIS 5266⁹ Page		

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) Bilateral Necrotizing Pulver Pneumonia		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) 490x		
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 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 a.m. p.m.	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 _____ to _____ and last saw her/him alive on _____
Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Deputy Registrar		22b. ADDRESS 1300 Claes		22c. DATE SIGNED 2-25-63	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 2-27-63		23c. NAME OF CEMETERY OR CREMATORY GREENWOOD	
24. FUNERAL DIRECTOR ADDRESS PRICE UND. CO 2829 Washington		25. DATE RECD. BY LOCAL REG. FEB 26 1963		26. REGISTRAR'S SIGNATURE Lead Smith, M.D.	
23d. LOCATION (City, town, or county) (State) St Louis 22 MO					

USE BLACK INK OR TYPEWRITER RIBBON

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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 Edward P. Flynn

Licensed Embalmer No. 4444

P. O. Address St Louis mo

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.