

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-028562

DO NOT WRITE ON THIS STUB
AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3717 STATE FILE NUMBER

FILED JUL 22 1963

1. PLACE OF DEATH a. COUNTY <u>Jackson</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u> Length of stay in 1b <u>D.O.A.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Kansas</u> b. COUNTY <u>Johnson</u> c. CITY OR TOWN <u>Overland Park</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>105th + Mission Rd</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St Marys Hosp</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		4. DATE OF DEATH Month <u>7</u> Day <u>2</u> Year <u>63</u>	

3. NAME OF DECEASED (Type or print) First <u>Marshall</u> Middle <u>Thomas</u> Last <u>Norman</u>			4. DATE OF DEATH Month <u>7</u> Day <u>2</u> Year <u>63</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>11-15-99</u>	9. AGE (last birthday) <u>63</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Rest mgr. Saddle & Billion Club.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>St John Mo</u>	
11. BIRTHPLACE (City and state or country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Minter Norman</u>		13b. MOTHER'S MAIDEN NAME <u>Ida Hancock</u>	
14. NAME OF HUSBAND OR WIFE <u>Mona L. Norman</u>		17. INFORMANT Address <u>Mona Norman 105th + Mission</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u> </u>	

18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Hypertensive Cardiovascular 2 yrs</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>few hours</u>
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 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.)	
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20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> 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
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21. I attended the deceased from 10/11/55 to July 2, 1963 and last saw him alive on June 28, 1963
 Death occurred at 10:15⁺ pm on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Print or title) <u>Orval J. Needels MD</u>	22b. ADDRESS <u>7400 Wornell KCo</u>	22c. DATE SIGNED <u>July 3, 1963</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>7-5-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Powersville Cemetery</u>	23d. LOCATION (City, town, or county) <u>Powersville Mo.</u>
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24. FUNERAL DIRECTOR <u>Comstock Funeral Home</u>	25. DATE RECD. BY LOCAL REG. <u>7-3-63</u>	26. REGISTRAR'S SIGNATURE <u>Ruth Song</u>
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(Licensed Embalmer's Statement on Reverse Side)

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 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
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 ITEM NO.

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF Orval J. Needels

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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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.