MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

5884

MAR 21 1929
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1. PLACE OF DEATH
County: Cole
Township: Clark
City: ..... (No. ....., ... St. ..... Ward)
Registration District No. 212
Primary Registration District No. 5292
File No. .....
Registered No. 7

2. FULL NAME: Premature Birth — Norfleet

(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Single

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Feb 6 - 1929

7. AGE: YEARS | MONTHS | DAYS | If LESS than 1 day, ... hrs. or 15 min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Cole Co Mo

PARENTS
10. NAME OF FATHER: Ralph Norfleet
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Cole Co Mo
12. MAIDEN NAME OF MOTHER: Pearl Henley
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Cole Co Mo

14. INFORMANT (Address): Ralph Norfleet Henley Mo

15. FILED Mar 10 1929 T. L. Glover REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Feb 6 1929

17. I HEREBY CERTIFY, That I attended deceased from Feby 6, 1929, to Feby 6, 1929, that I last saw him alive on Feby 6, 1929 and that death occurred, on the date stated above, at 6 25 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Premature Birth.

159 16 10

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) Dr T. L. Glover, M. D
Feb 6, 1929 (Address) Eugene Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Family Cemetery
DATE OF BURIAL: Feb 7 1929

20. UNDERTAKER: E. A. Schell
ADDRESS: Eugene Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.