

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.

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

406
Do not use this space.

REC'D FEB 10 1939

791
1003

Registered No. 406

1. PLACE OF DEATH
(a) County..... Registration District No.....
(b) Township..... Primary Registration District No.....
(c) City..... St. Louis..... (d) Street No. City Hospital No. 1 St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.
D. 14708

2. PRINT FULL NAME William Norrell
(a) Residence, No. 15 North 3rd St. 25 (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

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) July 26, 1880

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hra. ormin.
58 5 15

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc. laborer
10. Date deceased last worked at this occupation (month and year).....
11. Total time (years) spent in this occupation.....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Arkansas

13. NAME Phelan Norrell

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Arkansas

15. MAIDEN NAME Elizabeth Smith

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Arkansas

17. INFORMANT Hosp. Info. M. Kent (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE Memorial Park DATE 1/14 1939

19. FUNERAL DIRECTOR (NAME) Peetz Bros (ADDRESS) 3009 Lafayette

20. FILED JAN 18 1939 J. P. Budeck Death Registry

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1/11/39 19

22. I HEREBY CERTIFY, That I attended deceased from 1/9/39 19 to 1/11/39 19
I last saw him live on 1/11/39 19. Death is said to have occurred on the date stated above, at 6.30 A
The principal cause of death and related causes of importance were as follows:
Generalized Peritonitis
Perforated gastric ulcer 1/7/39
Other contributory causes of importance:
Name of operation: Exploratory Laparotomy Date of 1/10/39
What test confirmed diagnosis? Operation Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide?..... Date of injury....., 19.....
Where did injury occur?..... (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury.....
Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify.....
(Signed) William H. Elliott, M.D.
(Address) City Hospital No. 1

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

J. J. Owens

Licensed Embalmer No. *2245*

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.