

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

NOV 27 1939

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

36239
Do not use this space.

1. PLACE OF DEATH

(a) County Howell Registration District No. 384
(b) Township West Plains Primary Registration District No. 4227
(c) City West Plains or West Plains (d) Street No. _____ 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. 1 ds. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

655 William Albert Norman
(a) Residence, No. _____ St. Jefferson City, Mo.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct. 5, 1906

7. AGE YEARS 33 MONTHS 1 DAYS 9 IF LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION 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. Salesman
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) Alton, Mo. (STATE OR COUNTRY)

FATHER 13. NAME William Albert Norman, Sr.

14. BIRTHPLACE (CITY OR TOWN) Alton, Mo. (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME Zettie Johnson

16. BIRTHPLACE (CITY OR TOWN) Alton, Mo. (STATE OR COUNTRY)

17. INFORMANT Joe Norman, Alton, Mo. (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE Morrisville, Mo DATE 11/16/39

19. FUNERAL DIRECTOR (NAME) Leo Carr (ADDRESS) Thayer, Mo.

20. FILED 11-14 1939 Linda W SIMONS Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov. 14 1939

22. I HEREBY CERTIFY, That I attended deceased from Nov 14, 1939, to Nov 14, 1939. I last saw him alive on Nov 14, 1939. Death is said to have occurred on the date stated above, at 5:45 p. m. The principal cause of death and related causes of importance were as follows:

Acute Nephritis & Uremic Poison

Other contributory causes of importance: none that I know

Name of operation _____ Date of _____
What test confirmed diagnosis? Singh's test Was this an autopsy? _____

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? no 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. none only above mentioned

Manner of injury none
Nature of injury none

24. Was disease or injury in any way related to occupation of deceased? _____ If so, specify _____ (Signed) L. W. Simons, M. D.

(Address) Alton Mo

120
Joseph A. Ryan

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.....

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