

FILED MAR 11 1940

Registration District No. **599**

Primary Registration District No. **1002**

Registrar's No. **538**

1. PLACE OF DEATH:  
(a) County Jackson  
(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution St Joseph's Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 6 days (Specify whether  
In this community 44 years years, months or days)

3. (a) PRINT FULL NAME 62 Mrs Nagel Anna Norst  
3. (b) If veteran, name war No 3. (c) Social Security No. No

4. Sex fe 5. Color or race Wh 6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife Roy J. M. Norst 6. (c) Age of husband or wife if alive 49 years  
7. Birth date of deceased Nov. 18 1891 (Month) (Day) (Year)

8. AGE: Years 48 Months 2 Days 16 If less than one day hr. min.

9. Birthplace Toronto Canada (City, town, or county) (State or foreign country)

10. Usual occupation at home

11. Industry or business

MOTHER FATHER { 12. Name Walter Turner  
13. Birthplace London England (City, town, or county) (State or foreign country)  
14. Maiden name Anna Nurd  
15. Birthplace Ontario Canada (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Roy J M Norst  
(b) Address 2208 E 70th St

17. (a) Burial (b) Date thereof 2-6-40 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Forest Hill cemetery

18. (a) Signature of funeral director J. W. Wagoner

(b) Address Kansas City Mo

19. (a) Feb. 5, 1940 (Date received local registrar) (b) M. M. Brown (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Jackson  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2208 E. 70th St. (If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 4th year 1940 hour 8 minute 9 P. M.

21. I hereby certify that I attended the deceased from Dec. 6 '39, 1939, to Feb. 4, 1940; that I last saw him alive on Feb 4 '40 and that death occurred on the date and hour stated above.

Immediate cause of death CORONARY OCCLUSION Duration 10 DAY  
Due to ACUTE ASTHMA AND 6 WKS

Due to CIRCULATORY FAILURE 1 DAY

Other conditions 0 (Include pregnancy within 3 months of death)

Major findings: Of operations 0 Of autopsy 0 PHYSICIAN —  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature O. C. Lutzgard (M. D. or other) PH.D.  
Address 6944 Brown Ave Date signed Feb 5 1940

I X1931 USE UNFADING BLACK INK—MAKE 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.

Mr. C. W. ...  
6944 Prospect  
Sec 4793

**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 Cecil R Matthes

Licensed Embalmer No. 3807

P. O. Address H. E. M

**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.**