

FILED MAR 11 1940

Registration District No. **399**

Primary Registration District No. **1002**

Registrar's No. **878**

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: **Mercy Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether)

In this community **620**
years, months or days

3. (a) PRINT FULL NAME **Thos. S. Norris, Jr.**

3. (b) If veteran, name war. _____ 3. (c) Social Security No. _____

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Single**

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **Oct 24, 1924**
(Month) (Day) (Year)

8. AGE: **15** Years **4** Months **1** Days If less than one day _____ hr. _____ min.

9. Birthplace **Newport Arkansas**
(City, town, or county) (State or foreign country)

10. Usual occupation **at school**

MOTHER FATHER
11. Industry or business _____
12. Name **Thos. S. Norris, Sr.**
13. Birthplace **Galveston Tex**
(City, town, or county) (State or foreign country)
14. Maiden name **Blanche Harris**
15. Birthplace **La Crosse Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Thos. S. Norris, Jr.**

(b) Address **Route #1 - Lees Summit Mo.**

17. (a) **Burial** (b) Date thereof **7/27/40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Bus Springs, Mo.**

18. (a) Signature of funeral director **George C. Casper**

(b) Address **Independence Mo.**

19. (a) **2-26-40** (b) **M. M. Browne**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Jackson**
(c) City or town **Lees Summit**
(If outside city or town limits, write "RURAL")
(d) Street No. **RURAL - Route #1**
(If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month **Feb.** day **25**
year **1940** hour **12:55** minute _____ A. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death **Acute Pulmonary Edema**

Due to **breath**

Due to **Acute Glomerular Nephritis**

Other conditions **Essential hypertension several weeks ago**

Major findings: Of operations _____

Of autopsy _____

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? **361**

While at work? _____ (Specify type of place) (e) Means of injury **if**

23. Signature **Wesley D. ...** (M. D. or other)

Address **...** Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 *Donald L. B...*

Licensed Embalmer No. *2467*

P. O. Address *Indep. Mo*

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.