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9
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County **St. Louis, Missouri**

(b) City or town **St. Louis, Missouri**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. Louis City Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **3 Mos. 27 Days**
(Specify whether **50 years**)

In this community **50 years**
years, months or days

3. (a) PRINT FULL NAME **Sally L. Norris**

3. (b) If veteran, name war **none**

3. (c) Social Security No. **none**

4. Sex **Female** | 5. Color or race **White**

6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Clayton Norris**

6. (c) Age of husband or wife if alive **64 years**

7. Birth date of deceased **Feb. 14 1879**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
63	3	13	hr. min.

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

10. Usual occupation **Housewife**

11. Industry or business

MOTHER FATHER

12. Name **Unknown**

13. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

14. Maiden name **Unknown**

15. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant **Clayton Norris**

(b) Address **2519a N. Market St**

17. (a) **Burial** (Burial, cremation, or removal)

(b) Date thereof **May 30-42**
(Month) (Day) (Year)

(c) Place: burial or cremation **St. Peters Cem**

18. (a) Signature of funeral director **Hy. Leidner Und. Co.**

(b) Address **2223 St. Louis Ave.**

19. (a) **MAY 27 1942** (Date received local registrar)

(b) **J. J. Brueck** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **000**

(c) City or town **St. Louis** **2017**
(If outside city or town limits, write "RURAL")

(d) Street No. **2519a N. Market St.**
(If rural, give location)

(e) Citizen of foreign country? **0** (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **27**, year **1942** hour **12:25** minute **A.** M.

21. I hereby certify that I attended the deceased from **January 30**, 19**42** to **May 27**, 19**42** that I last saw him or her alive on **May 27**, 19**42** and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral arteriosclerosis** **months** Duration

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: Of operations

Of autopsy **not done**

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? **NA Carly** (Specify type of place) (b) Means of injury **(T)**

23. Signature **NA Carly** (M. D. or other)

Address **1515 Lafayette Avenue** Date signed **5/27/42**

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 *John P. Buckholz*
Licensed Embalmer No. *1674*
P. O. Address *2223 St Louis Ave*

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, fact should be so stated above.