

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED JUL 20 1942

Registration District No. 266

Primary Registration District No. 4164

Registrar's No. 3

1. PLACE OF DEATH:

(a) County Deuts
(b) City or town Salem, Mo.
(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 82 years. (Specify whether)
years, months or days

3. (a) PRINT FULL NAME Elisha Thomas Norris

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

4. Sex M. 5. Color or race W. 6. (a) Single, widowed, married, divorced M.
6. (b) Name of husband or wife Cornie Norris 6. (c) Age of husband or wife if alive 83 years
7. Birth date of deceased July - 29 - 1859
(Month) (Day) (Year)

8. AGE: Years 82 Months 5 Days 7 If less than one day _____ hr. _____ min.

9. Birthplace Deuts Mo. (City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER { 12. Name No Record.
18. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name Sarah Nelson.
15. Birthplace No Record. (City, town, or county) (State or foreign country)

16. (a) Informant Peard Butts
(b) Address Salem, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-7-42. (Month) (Day) (Year)
(c) Place: burial or cremation Union Cemetery

18. (a) Signature of funeral director Robert Southam
(b) Address Salem, Mo.

19. (a) 1-6-42 (Date received local registrar) (b) T. E. Butler, M.D. (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Deuts ³³
(c) City or town Salem (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U.S.A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 6
year 1941 hour 2 minute 25 A.M.

21. I hereby certify that I attended the deceased from Jan 5, 1941, to Jan 5, 1942, that I last saw him alive on Jan 3, 1941, and that death occurred on the date and hour stated above.

Immediate cause of death Stroke
Due to _____
Due to Hypertension

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

Major findings: Of operations _____
Of autopsy ✓

Duration

5 days

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 Stroke

23. Signature T. E. Butler, M.D. (M. D. or other) MD.
Address Salem, Mo. Date signed 1-6-42

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

RECEIVED

District Health Officer No. 6,

District File Number 442302

Date Filed 7.17-72

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 Max L. Warfel
Licensed Embalmer No. 4170
P. O. Address Salem, 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 21057

Registration District No. 264

Primary Registration District No. 4164

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Went
Salem

(b) City or town _____
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____
(If outside city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location)

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

3. (a) PRINT FULL NAME Elisha J Norris

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan Day _____
year 1942 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____
that I last saw him _____ alive on _____, 19____
and that death occurred on the date and hour stated above.
Immediate cause of death _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

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

7. Birth date of deceased July 29 1859
(Month) (Day) (Year)

Due to epidemic Chanc

Due to Influenza

Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

1312

8. AGE: Years 82 Months 5 Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

{ 13. Birthplace _____
(City, town, or county) (State or foreign country)

{ 14. Maiden name _____

{ 15. Birthplace _____
(City, town, or county) (State or foreign country)

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

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 [Signature] (M. D. or other) _____

Address Salem Mo Date signed Aug 24 42

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

SUPPLEMENTARY

