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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

18181

FILED JUN 11 1943 3

State File No. ....

Registration District No. ....

Primary Registration District No. **3031**

Registrar's No. **31**

1. PLACE OF DEATH:

(a) County Jefferson

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

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

(d) Length of stay: In hospital or institution None  
(Specify whether)

In this community 60 YEARS  
years, months or days

2. USUAL RESIDENCE OF DECEASED: **50**

(a) State Missouri (b) County Jefferson **2**

(c) City or town DeSoto  
(If outside city or town limits, write "RURAL") **2**

(d) Street No. 619 Flucom Road  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country.....

3. (a) PRINT FULL NAME JOHN SAMUEL NORRIS

3. (b) If veteran, name war No

3. (c) Social Security No.         

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

6. (b) Name of husband or wife Julia Roger 6. (c) Age of husband or wife if alive 70 years

7. Birth date of deceased June 10, 1871  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

71 | 11 | 0 |          hr.          min.

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

10. Usual occupation Stone Mason

11. Industry or business

MOTHER FATHER

12. Name Jerry Norris

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

14. Maiden name Zoia Merrill

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

16. (a) Informant Blanche Mae Goodwin

(b) Address 619 Flucom Rd De Soto Mo.

17. (a) Burial (b) Date thereof May 12 1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation DeSoto, Mo. City

18. (a) Signature of funeral director Lee Mothershead

(b) Address DeSoto, Mo.

19. (a) 5-11-43 (b) Fern Spencer  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 10  
year 1943 hour 4 minute          A.M.

21. I hereby certify that I attended the deceased from May 9 1943 to May 10 1943  
that I last saw her alive on May 9 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia **Duration**

Due to.....

Due to.....

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

Major findings:  
Of operations.....

Of autopsy.....

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 Dr. J. A. Palmer (M.D. or other) Dr.  
Address De Soto Date signed 5/10/43

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.....

*J. Lee Mothershead*

Licensed Embalmer No. *3531*

P. O. Address *D. S. to 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, fact should be so stated above.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. 163

Primary Registration District No. 3031

Registrar's No. 31

**1. PLACE OF DEATH:**  
 (a) County Jefferson  
 (b) City or town Leebato  
(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 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** John Samuel Harris  
 3. (b) If veteran, name war \_\_\_\_\_  
 3. (c) Social Security No. \_\_\_\_\_

**MEDICAL CERTIFICATION**  
 20. DATE OF DEATH: Month Mar Day 10 Year 1943 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.

4. Sex M 5. Color or race W  
 6. (a) Single, widowed, married, divorced \_\_\_\_\_  
 6. (b) Name of husband or wife \_\_\_\_\_  
 6. (c) Age of husband or wife if alive \_\_\_\_\_ year \_\_\_\_\_ month \_\_\_\_\_ day \_\_\_\_\_

Immediate cause of death Pneumonia & Bronchial Duration \_\_\_\_\_

**8. AGE:** Years 71 Months 1 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min. \_\_\_\_\_  
 9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country) Mo.

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

**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)

Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_  
**PHYSICIAN**  
 Underline the cause to which death should be charged statistically.

16. (a) Informant \_\_\_\_\_  
 (b) Address \_\_\_\_\_  
 17. (a) \_\_\_\_\_ (Burial, cremation, or removal) (b) Date thereof \_\_\_\_\_ (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) (c) Means of injury \_\_\_\_\_  
 23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
 Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTAL

5-18187

CA Rehm DC  
Doyle