

Dr Leslie 21372
State File No. _____
Registrar's No. 515

FILED JUL 8 1943
Registration District No. _____

Primary Registration District No. 5465

1. PLACE OF DEATH: **GREENE**

(a) County Greene

(b) City or town n. Springfield Miss.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Route 11
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution None
(Specify whether years, months or days)

In this community 7 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene

(c) City or town n. Springfield Miss. (Rural)
(If outside city or town limits, write "RURAL")

(d) Street No. Route 11
(If rural, give location)

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

3. (a) PRINT FULL NAME Margaret Adeline Norman

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, Widowed

6. (b) Name of husband or wife John F. Norman

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

7. Birth date of deceased February 15, 1856
(Month) (Day) (Year)

8. AGE: Years 87 Months 4 Days 10 If less than one day hr. _____ min. _____

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

10. Usual occupation In Home

11. Industry or business _____

MOTHER FATHER { 12. Name Thomas Alexander

13. Birthplace Unknown Tennessee
(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 Mrs. Charles Stokes

(b) Address Springfield, Missouri

17. (a) Burial (b) Date thereof June 29, 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Leslie, Arkansas

18. (a) Signature of funeral director Alma Lohmeyer Funeral Home

(b) Address Springfield, Missouri

19. (a) 6-39-43 (b) W. H. Haudley
(Date rec'd. local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 25
year 1943 hour 9:25 minute _____ P. A. M.

21. I hereby certify that I attended the deceased from July 1941 to June 25, 1943
that I last saw her alive on June 25, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia, hyperstatic

Due to Myocardiac insufficiency caused from hypertensive heart disease

Due to _____

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

Major findings: _____
Of operations _____

Of autopsy None

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? _____

23. Signature W. H. Haudley (M. D. or other) _____
Address Springfield, Mo. Date signed 5/28/43

Duration 2 days

3 yrs

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

944

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

STATEMENT BY LICENSED EMBALMER

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.....

Lewis G. Schopf

Licensed Embalmer No.

3802

P. O. Address.....

Springfield, 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, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1111
Registrar's No. 5-15

Registration District No. 138

Primary Registration District No. 5465

1. PLACE OF DEATH:

(a) County Greene
(b) City or town Rural
(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) 7 yrs

3. (a) PRINT FULL NAME Margaret A Norman

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

4. Sex F 5. Color or race w

6. (a) Single, widowed, married, divorced wid

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

7. Birth date of deceased: (Month) _____ (Day) _____ (Year) _____

8. AGE: Years 87 Months 4 Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof: (Month) _____ (Day) _____ (Year) _____

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Registrar's signature)

(Date received local registrar)

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Greene
(c) City or town Rural
(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan 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.

Immediate cause of death _____

Due to Pneumonia, hypertensive, Pneumonia lobar

Due to _____

Other conditions (Include pregnancy within 3 months of death) 108

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? _____

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

23. Signature Leslie R Webb (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

SUPPLEMENTARY

S-21372