

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Gullett 31165
State File No.

FILED OCT 1 1943
Registration District No. 11943

Primary Registration District No. 11050

Registrar's No.

1. PLACE OF DEATH

(a) County Copas
(b) City or town Harrison
(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 yes years, months or days

3. (a) PRINT FULL NAME MARY LOVENIA NORRIS

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

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife Henry A Norris 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Oct 25 1888 (Month) (Day) (Year)

8. AGE: Years 83 Months 9 Days 21 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name W.P. Robinson
13. Birthplace Ky (City, town, or county) (State or foreign country)
14. Maiden name Mary Lawrence
15. Birthplace Callaway Co Mo (City, town, or county) (State or foreign country)

16. (a) Informant Walter N Stewart

(b) Address Harrison Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 18 43 (Month) (Day) (Year)

(c) Place: burial or cremation Heckory Grove

18. (a) Signature of funeral director Wm. H. Gullett

(b) Address Centerville Mo

19. 8/18-1943 (Date received local registrar) (b) Mrs H. Gullett (Registrar's Signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County 11
(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 16 - 43
year 1943 hour 10 minute 15 P.M.

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

Immediate cause of death Myocardial Regeneration

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____

Duration

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 H. Gullett (M. D. or other)

Address Harrison Mo Date signed _____

76 (Licensed Embalmer's Statement on Reverse Side)

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

7-39
K32873

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 *Edmond Reed*

Licensed Embalmer No. *4313*

P. O. Address *Centralia 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. _____
Registrar's No. _____

Registration District No. 39 Primary Registration District No. _____

1. PLACE OF DEATH:
(a) County Boone
(b) City or town Harrisonburg
(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)

3. (a) PRINT FULL NAME Mary Laveria Norris
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

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

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

7. Birth date of deceased oct 25
(Month) (Day) (Year)

8. AGE: Years 83 Months 9 Days 7 If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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)

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) _____ (Date received local registrar) (b) Mrs. H. Shultz (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State MO (b) County Boone
(c) City or town Harrisonburg (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 aug day 9 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 _____

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) (c) Means of injury _____

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

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

MOTHER FATHER

SUPPLEMENTARY

77 100 77

FILED

31165