

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 31458  
Registrar's No. 79

Registration District No. 1943 Primary Registration District No. 3013

1. PLACE OF DEATH:  
(a) County Clay  
(b) City or town North R.C. Mo.  
(c) Name of hospital or institution:  
1037 - East 22nd Street -  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution none  
In this community 20 years  
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo (b) County Clay  
(c) City or town North - R.C. Mo.  
(d) Street No. 1037 East - 22nd St  
(If rural, give location)  
(e) Citizen of foreign country? (Yes or No) 0  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME AURA FRANCIS MEAD-NORRIS  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Sept day 19th.  
year 1943 hour 9:30 minute A.M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_  
to \_\_\_\_\_, 1943  
that I last saw him alive on September - 19, 1943  
and that death occurred on the date and hour stated above.

4. Female 5. Color of race White 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Charles Leroy Norris 6. (c) Age of husband or wife if alive 61 years  
7. Birth date of deceased Dec - 19 - 1889  
(Month) (Day) (Year)

Immediate cause of death Progressive Ventricular fibrillation  
Due to Possible pericardial embolism  
Due to Site undetermined  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Duration \_\_\_\_\_

8. AGE: Years 53 Months 9 Days 0 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Plattsburg - Mo Clinton Co.  
(City, town, or county) (State or foreign country)  
10. Usual occupation Housewife  
11. Industry or business \_\_\_\_\_  
12. Name Lloyd - Mead  
13. Birthplace Virginia  
(City, town, or county) (State or foreign country)  
14. Maiden name Mary Carter  
15. Birthplace Plattsburg - Mo.  
(City, town, or county) (State or foreign country)

Major findings: Of operations \_\_\_\_\_  
Of autopsy yes 9-19-43  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant Lloyd Norris  
(b) Address 1020 East 23rd St - Plattsburg  
17. (a) Burial (b) Date thereof Sept 20, 43  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Plattsburg Mo  
18. (a) Signature of funeral director Morton Finney  
(b) Address North R.C. Mo  
19. (a) Sept 20 - 43 (b) Ruth N. Henry  
(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 Prince & Dodge (M. D. or other) \_\_\_\_\_  
Address North Consistency Mo Date signed 9-20-43

1121 (Licensed Embalmer's Statement on Reverse Side) Wm. H. ...

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

MOTHER FATHER

RECEIVED

District Health Officer No. 88

District File Number

Date Filed

10-7-43

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 S. Marton

Licensed Embalmer No. 4349

P. O. Address

No. Kansas City 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. oct  
Registrar's No. 79

Registration District No. 12 Primary Registration District No. 3013

1. PLACE OF DEATH:  
(a) County Clay  
(b) City or town North Kansas City  
(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 (Specify whether)  
years, months or days

3. (a) PRINT FULL NAME Laura J Mead Harris  
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 m  
6. (b) Name of husband or wife 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Dec 19 1885  
(Month) (Day) (Year)

8. AGE: Years 53 Months 9 Days \_\_\_\_\_ (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)  
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) (Registrar's signature)

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 \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Sept 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 Operated for Fibroid of uterus.  
Due to No malignancy

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations 568  
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 James E. Dodge (M. D. or other) \_\_\_\_\_  
Address North Kansas City Date signed 10/15/43

SUPPLEMENTARY

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

MOTHER FATHER

PHYSICIAN  
Underline the cause to which death should be charged statistically.

31458