

No. 2  
4-2  
5-17  
I X35897

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **31842**  
Registrar's No. **505**

Registration District No. **156** Primary Registration District No. **2001**

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

1. PLACE OF DEATH:  
(a) County **Jasper**  
(b) City or town **Joplin**  
(c) Name of hospital or institution: **St. Johns Hosp;**  
(d) Length of stay: In hospital or institution **2 days;**  
In this community **30 years**

3. (a) PRINT FULL NAME **Norah Haley**  
3. (b) If veteran, name war **No** 3. (c) Social Security No. **No**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **widow**  
6. (b) Name of husband or wife **H.D. Haley** 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased **April 11, 1874**

8. AGE: Years **69** Months **4** Days **23** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation **retired housewife**

11. Industry or business \_\_\_\_\_  
12. Name **Shellenbarger**  
13. Birthplace **No record**  
14. Maiden name **Reece**  
15. Birthplace **No record**

16. (a) Informant **W. H. Harrison**  
(b) Address **2107 Murphy Ave; Joplin Mo;**  
17. (a) **Burial** (b) Date thereof **9-5-43;**  
(c) Place: burial or cremation **Ozark Mem. Cem.**  
18. (a) Signature of funeral director **Hurlbut Und. Co;**  
(b) Address **Joplin Mo;**  
19. (a) **9-3-43** (b) **W. H. Harrison**

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Missouri** (b) County **Jasper 049**  
(c) City or town **Joplin**  
(d) Street No. **2107 Murphy Ave;**  
(e) Citizen of foreign country? **No**  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **Sept. 3** day **1943**  
year \_\_\_\_\_ hour **5-45 A.** Minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from **5/10 - 9-3**  
19**43** to **9-3** 19**43**  
that I last saw **or** alive on **9-2** 19**43**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Paralytic**  
Due to **Myocarditis - Chr**  
**incontinence**  
Due to **Paralytic**  
Other conditions (Include pregnancy within 3 months of death) **93d**

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 **W. H. Harrison** (M. D. or other) **9-3-43**  
Address **Joplin Mo** Date signed \_\_\_\_\_

Duration **20 hrs**  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

42-9-782

---

---

**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.....

Licensed Embalmer No. 959

P. O. Address Japan, Miss

**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.**