

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **36757**
Registrar's No. **10007** ✓

FILED NOV 29 1943
Registration District No. **318**

Primary Registration District No. **1003**

1. PLACE OF DEATH:
(a) County **St. Louis**
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **2407 Hadley Street**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **50 years** (Specify whether years, months or days)
In this community **50 years** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **000**
(c) City or town **St. Louis** **1796**
(If outside city or town limits, write "RURAL") **9V**
(d) Street No. **2407 Hadley St.** (If rural, give location)
(e) Citizen of foreign country? **0** (Yes or No)
If yes, name country **0**

3. (a) PRINT FULL NAME **Lena Mary Fitzgarld Norris**
3. (b) If veteran, name war **none**
3. (c) Social Security No. **none**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Nov.** day **12**
year **1943** hour **9:15** minute **P.** M.
21. I hereby certify that I attended the deceased from **Nov. 8** 1943 to **Nov. 12** 1943;
that I last saw her alive on **Nov. 12** 1943;
and that death occurred on the date and hour stated above.

4. Sex **female** 5. Color or race **white**
6. (a) Single, widowed, married, divorced **1 1 1 2**
6. (b) Name of husband or wife **late John Norris**
6. (c) Age of husband or wife if alive **—** years
7. Birth date of deceased **march** **1876**
(Month) (Day) (Year)

Immediate cause of death **Angina pectoris**
Due to **Chronic myocarditis + Arterial sclerosis**
Due to **10 yrs**
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations **93**
Of autopsy **93**

8. AGE: Years **off 67** Months **8** Days **—**
If less than one day hr. min.
9. Birthplace **Ky.** (City, town, or county) (State or foreign country)

10. Usual occupation **House work**
11. Industry or business
12. Name **Ben F. Newton**
13. Birthplace **Ky.** (City, town, or county) (State or foreign country)
14. Maiden name **Unknown**
15. Birthplace **Ky.** (City, town, or county) (State or foreign country)

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

16. (a) Informant **Mr. Lloyd Newton**
(b) Address **1342 N. Euclid Ave.**
17. (a) **Burial** (b) Date thereof **11-15-43**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Cape Girardeau, Mo.**
18. (a) Signature of funeral director **Hy. Leidner U. Co.**
(b) Address **2223 St. Louis Ave.**
19. (a) **NOV 16 1943** (b) **J. F. Breeseck**
(Date received local registration) (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 **John C. Creane** (M. D. or other) **M.D.**
Address **2504 N. 14th St** Date signed **11-15-43**

MOTHER FATHER

20007

20007

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 F. Buehholz*

Licensed Embalmer No..... 667

P. O. Address..... 2223 St Louis

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. Dec
Registrar's No. 10007

Registration District No. 218

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County.....
(b) City or town..... St. Louis
(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)

3. (a) PRINT FULL NAME Lena M. J. 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 Widow
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive.....

7. Birth date of deceased March (Month) 1 (Day) 1943 (Year)

8. AGE: Years 67 Months 8 Days 1 If less than one day, min. 1

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

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)

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) DEC 1 1943 (b) J. F. Budesh (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 Dec Day 1 Year 1943 Hour 10 minute 00 M.

21. I hereby certify that I attended the deceased from 1943 to 1943,
that I last saw him alive on 1943,
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.....

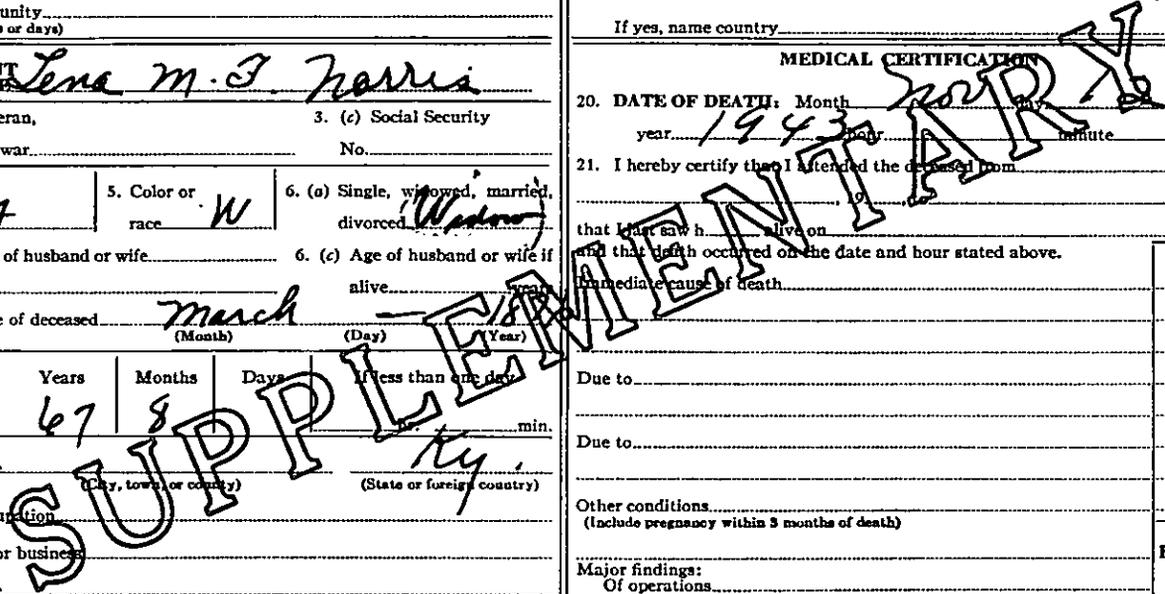
PHYSICIAN

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) (e) Means of injury.....

23. Signature..... (M, D. or other).....
Address..... Date signed.....



36757