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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 15 1944

Registration District No. ____

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 15691

Primary Registration District No. 3-0-6-0 6073

Registrar's No. ____

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

1. PLACE OF DEATH:

(a) County ST. FRANCOIS

(b) City or town RURAL NEAR FARMINGTON
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St Francois Co

(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)

In this community ____

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County ST FRANCOIS

(c) City or town NEAR FARMINGTON Alf
(If outside city or town limits, write "RURAL")

(d) Street No. 0
(If rural, give location)

(e) Citizen of foreign country? ____ (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME DORRIS ANN NORRIS.

3. (b) If veteran, name war ____

3. (c) Social Security No. ____

4. Sex F 1

5. Color or race W

6. (a) Single, widowed, married, divorced 0

6. (b) Name of husband or wife ____

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

7. Birth date of deceased APRIL (Month) 23 (Day) 1944 (Year)

8. AGE: Years ____ Months ____ Days ____ If less than one day 7 hr. ____ min.

9. Birthplace ST FRANCOIS CTY (City, town, or county) MO. (State or foreign country)

10. Usual occupation ____

11. Industry or business ____

FATHER

12. Name RAY MOND NORRIS

13. Birthplace FREDERICKTOWN (City, town, or county) MO. (State or foreign country)

MOTHER

14. Maiden name ~~FARMINGTON~~ ELLEN GRUNER

15. Birthplace FARMINGTON (City, town, or county) MO. (State or foreign country)

16. (a) Informant RAY MOND NORRIS

(b) Address FARMINGTON MO RT 1

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof APRIL 24 (Month) (Day) (Year)

(c) Place: burial or cremation K. of P. Cem.

18. (a) Signature of funeral director COZEAN Funeral Home

(b) Address FARMINGTON MO.

19. (a) 4-26-44 (Date received local registrar) (b) Jones Robins (Registrar's signature)

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(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 24 year 1944 hour 2:30 p.m. minute a. M.

21. I hereby certify that I attended the deceased from April 23, 1944, to April 24, 1944; that I last saw her alive on April 24, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Premature birth	7 hrs.
Due to	
Due to	

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

Major findings:
Of operations ____
Of autopsy ____

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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? ____ (Specify type of place)

While at work? ____ (e) Means of injury ____

23. Signature Geo. E. Walters (M. D. or other)

Address Farmington Mo. Date signed 4-24-44

RECEIVED 5-13-44

District Health Officer No. 4

District File Number 544-38

Date Filed 5-13-44

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.

not embalmed

Signed O H Cozean

Licensed Embalmer No. 4084

P. O. Address Farmington Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.