

No. 2  
5-43  
5-17-39  
X38671

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED AUG 18 1944

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 27967 ✓  
Registrar's No. 190

Registration District No. 176 Primary Registration District No. 3026

1. PLACE OF DEATH:  
(a) County JACKSON  
(b) City or town Kansas City Independence  
(c) Name of hospital or institution: 320 S. Fuller  
(d) Length of stay: In hospital or institution 4 weeks  
In this community years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State Illinois (b) County Massac  
(c) City or town Joppa  
(d) Street No.  
(e) Citizen of foreign country? (Yes or No)  
If yes, name country.

3. (a) PRINT FULL NAME Lillie Norwood  
3. (b) If veteran, name war. X  
3. (c) Social Security No. X  
4. Sex. Fe 5. Color or race Wh  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Enos Norwood  
6. (c) Age of husband or wife if alive 70 years  
7. Birth date of deceased Feb. 1, 1890

8. AGE: Years 54 Months 5 Days 25  
If less than one day hr. min.

9. Birthplace Massac Co. Ill  
10. Usual occupation Homemaker  
11. Industry or business At home

12. Name Samuel E. Smith  
13. Birthplace Ill  
14. Maiden name Martha Lynn  
15. Birthplace Ill

16. (a) Informant S.O. Smith  
(b) Address 320 S. Fuller, Indep. Mo.  
17. (a) Burial (b) Date thereof 7-28-44  
(c) Place: burial or cremation Mound Grove

18. (a) Signature of funeral director  
(b) Address  
19. (a) 7-28-1944 (b) James W. Ross

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month July day 26 year 1944 hour 2 minute 40 A.M.  
21. I hereby certify that I attended the deceased from June 29, 1944  
that I last saw her alive on July 26, 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death: Coronary thrombosis  
Due to Coronary sclerosis  
Due to Myocarditis Nephritis  
Other conditions: (Include pregnancy within 3 months of death)

Major findings: Of operations  
Of autopsy  
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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?  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
23. Signature: James W. Ross  
Address: 4717 E. 24th Date signed: 7/26/44

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

MOTHER FATHER

1163

(Licensed Embalmer's Statement on Reverse Side)

0822

02

0822

07

---

---

**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 H. O. Blackman

Licensed Embalmer No. 3639

P. O. Address R. E. 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.**

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

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

**1. PLACE OF DEATH:**  
 (a) County Jackson  
 (b) City or town Independence  
(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 Yunk. (Specify whether  
 years, months or days)

**3. (a) PRINT FULL NAME** Lillie Norwood  
 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 Feb. 1 1894  
(Month) (Day) (Year)

8. AGE: Years 54 Months 5 Days 21 If less than one day  
min.

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

10. Usual occupation \_\_\_\_\_

**MOTHER FATHER**  
 11. Industry or business \_\_\_\_\_  
 12. Name \_\_\_\_\_  
 13. Birthplace Ill. (City, town, or county) (State or foreign country)  
 14. Maiden name Ill.  
 15. Birthplace Ill. (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_  
 (b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_  
 (b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (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 July day 26  
 year 1944 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
 21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
 that I last saw him/her alive on \_\_\_\_\_, 19\_\_\_\_,  
 and that death occurred on the date and hour stated above.  
 Immediate cause of death \_\_\_\_\_

Coronary Thrombosis  
Coronary Sclerosis  
 Due to myocarditis  
nephritis (chronic)  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: **ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED**  
 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?  
 \_\_\_\_\_  
(Specify type of place)  
 While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

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

27967