

FILED OCT 1 1944

Registration District No. 3800

Primary Registration District No. 4423

Registrar's No. 44

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

1. PLACE OF DEATH:  
 (a) County Platte  
 (b) City or town Weston  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: None  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution no  
(Specify whether)  
 In this community Twenty Five years  
years, months or days

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri (b) County Platte 83  
 (c) City or town Weston  
(If outside city or town limits, write "RURAL") 0  
 (d) Street No. \_\_\_\_\_  
(If rural, give location)  
 (e) Citizen of foreign country? no (Yes or No)  
 If yes, name country 0

3. (a) PRINT FULL NAME Dave Newton Norris  
 (b) If veteran, name war no  
 (c) Social Security No. XX

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month August day 30  
 year 1944 hour 3 minute 30A M.

4. Sex male 5. Color or race white  
 6. (a) Single, widowed, married, divorced married  
 (b) Name of husband or wife Devora Ann Latham  
 (c) Age of husband or wife if alive 66 years  
 7. Birth date of deceased October 2 1874  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from March 30, 1943 to August 30, 1944  
 that I last saw him alive on August 30, 1944  
 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>69</u>	<u>10</u>	<u>28</u>	hr. _____ min. _____

Immediate cause of death Pulmonary tuberculosis  
 Duration 69 yrs

9. Birthplace Bath Co., Kentucky  
(City, town, or county) (State or foreign country)

Due to lighting up of inactive foci from hospitalization for traumatic rupture of urethra.  
 Tuberculosis was probably contracted in childhood.  
 Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

10. Usual occupation Farmer

MOTHER FATHER {  
 11. Industry or business \_\_\_\_\_  
 12. Name Albert Norris  
 13. Birthplace Bath Co., Kentucky  
(City, town, or county) (State or foreign country)  
 14. Maiden name Mary Jane Coyle  
 15. Birthplace xx Kentucky  
(City, town, or county) (State or foreign country)

Major findings: Of operations No operation for this condition.  
 Of autopsy None 3 fl  
 PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Dave Norris  
 (b) Address Weston Weston, Missouri

22. If death was due to external causes, fill in the following:  
 (a) Accident, suicide, or homicide (specify) XXXXXX

17. (a) Burial (b) Date thereof Sept. 1-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Where did injury occur? XXXX  
(City or town) (County) (State)

(c) Place: burial or cremation Pleasant Ridge Cem.  
Vaughn Funeral Home

(d) Did injury occur in or about home, on farm, in industrial place, in public place? XXXXX  
(Specify type of place)

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

While at work? XXX (e) Means of injury \_\_\_\_\_

19. (a) 9-1-44 (b) Mrs. Clay Siffel  
(Date received local registrar) (Registrar's signature)

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

**RECEIVED**  
District Health Officer No. Platte Co.  
District File Number 19-44-85  
Date Filed 10-3-44

**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.

Signed W. R. Vaughn

Licensed Embalmer No. 14023

P. O. Address.....

**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. act

Registration District No. 280

Primary Registration District No. 4423

Registrar's No. 44

1. PLACE OF DEATH:

(a) County P. latte  
(b) City or town Weston  
(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 \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME

Dave H. Harris

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex M 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 Oct. 2 (Month) (Day) (Year)

8. AGE: Years 69 Months 10 Days \_\_\_\_\_ If 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) \_\_\_\_\_ (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) 10-8-44 (b) Mrs. Clay Stiffee (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 \_\_\_\_\_ Day \_\_\_\_\_ Year 1944 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 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 \_\_\_\_\_

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 James C. Calvert (M. D. or other) \_\_\_\_\_

Address Weston, Mo. Date signed \_\_\_\_\_

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

SUPPLEMENTARY

31531