

FILED JUN 14 1945

Registration District No. 237

Primary Registration District No. 4380

Registrar's No. 82-

74  
000  
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:  
 (a) County Nodaway  
 (b) City or town Arkoe  
 (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 40 years (Specify whether years, months or days)  
 In this community \_\_\_\_\_

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

3. (a) PRINT FULL NAME Norman A. Laurence  
 (b) If veteran, name war none  
 (c) Social Security No. none

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month May day 9  
 year 1945 hour 8 minute 30 A.

4. Sex male  
 5. Color or race white  
 6. (a) Single, widowed, married, divorced widowed  
 (b) Name of husband or wife Katie Johnson  
 (c) Age of husband or wife if alive \_\_\_\_\_ years

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_  
 that I last saw him alive on May 5, 1945  
 and that death occurred on the date and hour stated above.

7. Birth date of deceased January 12, 1870  
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>75</u>	<u>3</u>	<u>27</u>	hr. _____ min. _____

Immediate cause of death Melanotic and Carcinoma  
 Duration \_\_\_\_\_

9. Birthplace Carrol County, Illinois  
 (City, town, or county) (State or foreign country)  
 10. Usual occupation retired merchant

Due to Ca of Prostate with Metastasis  
 Due to \_\_\_\_\_  
 Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

11. Industry or business \_\_\_\_\_  
 12. Name Albert Laurence  
 13. Birthplace Carrol Co. Ill.  
 (City, town, or county) (State or foreign country)  
 14. Maiden name Ann Linn  
 15. Birthplace Ann Linn use Linn  
 (City, town, or county) (State or foreign country)

Major findings: Of operations 5/11  
 Of autopsy \_\_\_\_\_  
 PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

16. (a) Informant Glenn Laurence  
 (b) Address Arkoe, Missouri  
 17. (a) burial (b) Date thereof 5-9-45  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Swingford cemetery

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? \_\_\_\_\_

18. (a) Signature of funeral director Price Funeral Home  
 (b) Address Marionville, Mo.  
 19. (a) May 24, 1945 Arney Barker  
 (Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place)  
 (e) Means of injury \_\_\_\_\_  
 23. Signature W.R. Fisher (M. D. or other) \_\_\_\_\_  
 Address Marionville, Mo. Date signed 5-10-45

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.

RECEIVED  
District Health Officer No. 11,  
District File Number.....  
Date Filed.....

Signed.....  
.....  
Licensed Embalmer No. 4281  
P. O. Address Maryville 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.