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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **3765**

FILED JAN 28 1946

Registration District No. 291

Primary Registration District No. 5998

Registrar's No. 90

1. PLACE OF DEATH

(a) County Putnam

(b) City or town Rural - York Township
(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 25 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Putnam

(c) City or town Rural
(If outside city or town limits, write "RURAL")

(d) Street No. Powersville 130
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME MARY HARRIET NORMAN

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Female 5. Color or race white

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

6. (b) Name of husband or wife Leavel Norman

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

7. Birth date of deceased November 11 1857
(Month) (Day) (Year)

8. AGE: Years 86 Months 0 Days 29 If less than one day hr. min.

9. Birthplace Waynes Co Iowa
(City, town, or county) (State or foreign country)

10. Usual occupation at home

11. Industry or business _____

MOTHER FATHER

12. Name Jacob Bergander SR

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

14. Maiden name Fannie Renale

15. Birthplace Norwaton England
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Ernest Smith

(b) Address Powersville Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 12 1945
(Month) (Day) (Year)

(c) Place: burial or cremation Waynes Co Iowa

18. (a) Signature of funeral director W. B. ...

(b) Address Waynes Co Iowa

19. (a) 12-31-45 (Date received local registry)

(b) Marshall Dunbar (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 10 year 1945 hour 1 minute 30 PM

21. I hereby certify that I attended the deceased from Dec 9 to Dec 10, 1945 that I last saw her alive on Dec 10, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac failure

Due to Lobar pneumonia

Due to _____

Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy 108

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 G. A. Dale (M.D. or other) P.O.

Address Newtown, Mo. Date signed 12/12/45

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD
100776

RECEIVED

District Health Officer No. 16

District File Number 1-46-126

Date Filed JAN 24 1946

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 D. Comstock*

Licensed Embalmer No. *3891*

P. O. Address *Thionville, 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.