

FILED DEC 29 1946

Registration District No. **128**

Primary Registration District No. **5466**

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

1. PLACE OF DEATH:

(a) County **GREENE**

(b) City or town **Rural, S. Campbell Twp.**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution **OZARK OSTEOPATHIC HOSPITAL**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **8 DAYS**
(Specify whether)

In this community **37 YEARS**
(years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **GREENE**

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

(d) Street No. **601 N. FORT**
(If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME **WALTER O. NORRIS**

3. (b) If veteran, name war **none**

3. (c) Social Security **None**

4. Sex **M**

5. Color or race **W**

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

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive **2** years

7. Birth date of deceased **MAY 9 1874**
(Month) (Day) (Year)

8. AGE: Years **72** Months ~~72~~ Days ~~200~~

If less than one day hr. min.

9. Birthplace **MURFREESBORO TENN.**
(City, town, or county) (State or foreign country)

10. Usual occupation **RETIRED LUMBERMAN**

11. Industry or business **Lumber**

12. Name **Unknown**

13. Birthplace **? Unknown**
(City, town, or county) (State or foreign country)

14. Maiden name **Unknown**

15. Birthplace **? Unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant **E. H. BRISTOW**

(b) Address **R.R. 1 STRAFFORD, Mo**

17. (a) **Burial** (b) Date thereof **12-12-1946**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Green Lawn Cem**

18. (a) Signature of funeral director **Worthington Co.**

(b) Address **Springfield, Mo**

19. (a) **12-12-46** (b) **W Z Handley (M.D.)**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **DEC** day **9**
year **1946** hour **12:00** minutes **20 A.M.**

21. I hereby certify that I attended the deceased from **12-1**, 1946, to **12-9**, 1946;
that I last saw him alive on **12-8**, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death **CEREBRAL HEMORRHAGE** **8 DAY**

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **MA**

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?

While at work? (Specify type of place) (e) Means of injury

23. Signature **Howard J. Mason** (M. D. or other) **D.O.**
Address **606 E. Sunshine - Springfield** Date signed **12-9-46**

DEC 8 1947

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..... *Max Rhodes*
Licensed Embalmer No..... *4071*
P. O. Address..... *Springfield*

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.