

Primary Registration District No. 1002

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

1. PLACE OF DEATH:  
 (a) County Jackson Co. Mo.  
 (b) City or town Jackson City Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: Farmers Hospital  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 14 da.  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Norval Hughes  
 3. (b) If veteran, name war ✓  
 3. (c) Social Security No. ✓  
 4. Sex Male 5. Color or race White  
 6. (a) Single, widowed, married, divorced ✓  
 6. (b) Name of husband or wife \_\_\_\_\_  
 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased July 6 1947  
(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days 14 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min. ✓

9. Birthplace Farmers Hospital Kan. City Mo.  
(City, town, or county) (State or foreign country)

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

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
 12. Name Norval Hughes  
 13. Birthplace Lawrence, Mo.  
(City, town, or county) (State or foreign country)  
 14. Maiden name Lotha Hughes  
 15. Birthplace Lawrence, Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant Farmers Hosp.

(b) Address Jackson City, Mo.

17. (a) Burial (b) Date thereof July 26-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn

18. (a) Signature of funeral director A. P. Doherty  
 (b) Address 1815 E. 15

19. (a) 7-25-47 (b) Heraldine Holme  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri (b) County Jackson  
 (c) City or town Jackson City  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 1417 E. 27  
(If rural, give location)  
 (e) Citizen of foreign country? no (Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 19  
 year 1947 hour 1:30 minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from July 6 1947 to July 19 1947  
 that I last saw him alive on July 19 1947  
 and that death occurred on the date and hour stated above.

Immediate cause of death Terminal Pneumonia

Due to Upper Respiratory Infection

Due to Malnutrition

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations 1142  
 Of autopsy yes

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? 0

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

23. Signature [Signature] (M. D. or other) 30-40  
 Address 1315 Broadside Plaza Date signed July 20-47

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**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.....

Licensed Embalmer No.....

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.**