

FILED JAN 27 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 3664

BIRTH NO. _____ REG. DIST. NO. 324 PRIMARY REG. DIST. NO. 3072 Registrar's No. 6

97
1
2

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

1. PLACE OF DEATH a. COUNTY Saline		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Saline	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Marshall, Mo.		c. LENGTH OF STAY (In this place) All His	
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Marshall		d. STREET ADDRESS (If rural, give location) 221 North Odell	
d. FULL NAME OF HOSPITAL OR INSTITUTION Fitzgibbons Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) Joseph b. (Middle) Shelby c. (Last) Norvell			4. DATE OF DEATH (Month) (Day) (Year) January 7/49		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced	8. DATE OF BIRTH 8/16/1885	9. AGE (In years last birthday) 63	IF UNDER 1 YEAR Months 4 Days 21
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Meat Cutter		10b. KIND OF BUSINESS OR INDUSTRY Butcher Shop	11. BIRTHPLACE (State or foreign country) Gilliam, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Frank H. Norvell	13b. MOTHER'S MAIDEN NAME Anna C. Howoker	14. NAME OF HUSBAND OR WIFE Divorced
--	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No.	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) No.	17. INFORMANT'S SIGNATURE OR NAME John Norvell, Marshall, Mo.	ADDRESS Marshall, Mo.
--	---	--	------------------------------

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Ac Parenchymatous Nephritis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) none known other DUE TO (c) Chronic Anemia L90		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Toxemia Metabolic Disturbance			

19a. DATE OF OPERATION 1-9-49	19b. MAJOR FINDINGS OF OPERATION Super Pubic Cystostomy (Retention)	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
---	--	----------------------------

22. I hereby certify that I attended the deceased from **Oct 19 1949** to **Jan 7 1949**, that I last saw the deceased alive on **Jan 3 1949**, and that death occurred at **2:15 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE Robert M. D. [Signature] (Degree or title)	23b. ADDRESS Marshall Mo	23c. DATE SIGNED 1-8-49
--	---------------------------------	--------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 1/9/49	24c. NAME OF CEMETERY OR CREMATORY Gilliam Cemetery	24d. LOCATION (City, town, or county) (State) Gilliam, Mo. Mo.
---	-------------------------	--	---

DATE REC'D BY LOCAL REG. Jan 8-1949	REGISTRAR'S SIGNATURE Sidney T. Gray	385	25. FUNERAL DIRECTOR'S SIGNATURE A. L. [Signature]	ADDRESS Marshall, Mo.
--	---	-----	---	------------------------------

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 1-26-49

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed J. Leslie Tussing

Licensed Embalmer No. 32358

P. O. Address Marshall, Va.

Signed _____
Student Embalmer

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.