

FILED AUG 29 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28507

State File No. _____

318

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. <u>1003</u>		Registrar's No. <u>6744</u>	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. LENGTH OF STAY (In this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Webster Groves</u> Co. <u>Co.</u>		d. STREET ADDRESS <u>410 Alma</u> (If rural, give location) <u>4607</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>Firmin DeBogge Hospital</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Aug. 6 1950</u>			
3. NAME OF DECEASED a. (First) <u>OSCAR</u> (Type or Print)		b. (Middle) <u>GILMAN</u>		c. (Last) <u>NORGAARD</u>		5. SEX <u>Male</u>	
6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>March 21 1909</u>		9. AGE (In years last birthday) <u>41</u> # UNDER 1 YEAR _____ # UNDER 1 MIN. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Red Cross WORK</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Hutton North Dakota</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Edward Norgaard</u>		13b. MOTHER'S MAIDEN NAME <u>Julia Olson</u>		14. NAME OF HUSBAND OR WIFE <u>Frances Norgaard</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Frances Norgaard 410 Alma Groves</u>			
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Malignant Hypertension</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) _____ DUE TO (c) _____ 2. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u> <u>Tuberculosis of left wrist</u>				INTERVAL BETWEEN ONSET AND DEATH <u>8 mo.</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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? <u>H/5X P</u>					
22. I hereby certify that I attended the deceased from <u>Dec 6, 1949</u> , to <u>Aug 6, 1950</u> , that I last saw the deceased alive on <u>Aug 7, 1950</u> , and that death occurred at <u>4 P. M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>James B. Stubbins, M.D.</u> (Degree or title) <u>0</u>				23b. ADDRESS <u>35 N. Central</u>		23c. DATE SIGNED <u>8-7-50</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Aug. 9 1950</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Resurrection</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis Mo.</u>	
DATE REC'D BY LOCAL REG. <u>AUG 8 1950</u>		REGISTRAR'S SIGNATURE <u>J. B. Frazier</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Parker-Aldrich Funeral Home</u> ADDRESS <u>46 Aldrich</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

334
L. H. ...

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.

Student
Student Embalmer

Signed *Leslie Welch* _____

Licensed Embalmer No. *4395* _____

P. O. Address *Robert Green* _____

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.