

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **23703**
 Registrar's No. **806**

FILED AUG 4 1952 REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000**

1. PLACE OF DEATH a. COUNTY Louichanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Louichanan	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph 0117	
d. FULL NAME OF HOSPITAL OR INSTITUTION. State Hospital no. 2,		d. STREET ADDRESS (If rural, give location) 1509 Prospect, Ave.	

3. NAME OF DECEASED (Type or Print)	a. (First) SARA H.	b. (Middle) FRANCIS	c. (Last) NORTON.	4. DATE OF DEATH (Month) (Day) (Year) 7-28-1952
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5. SEX Female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed, 2	8. DATE OF BIRTH 8-13-1884.	9. AGE (In years last birthday) 67	10. UNDER 1 YEAR 11	11. UNDER 12 HRS. 15
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Homemaker,	11. BIRTHPLACE (State or foreign country) Missouri,	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Elih Carroll	13b. MOTHER'S MAIDEN NAME Sumner,	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.	16. SOCIAL SECURITY NO. None,	17. INFORMANT'S SIGNATURE OR NAME Archie B. Norton - Leonard Road R.R. #7 St. Joseph	ADDRESS
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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		INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hours
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) arterio-sclerosis DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Psychosis		10 years	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 331X	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **5-6-**, 1952, to **7-28-**, 1952, that I last saw the deceased alive on **7-28-**, 1952, and that death occurred at **7:40 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE Fairst Thomas (Degree or title) M.D.	23b. ADDRESS State Hospital No. 2 St Joseph, Mo.	23c. DATE SIGNED 7-28-1952
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 7/31/1952	24c. NAME OF CEMETERY OR CREMATORY Forest Hill Cemetery	24d. LOCATION (City, town, or county) (State) St. Joseph, Mo.
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DATE REC'D BY LOCAL REG. July 31, 1952	REGISTRAR'S SIGNATURE Carl C. Castle	25. FUNERAL DIRECTOR'S SIGNATURE Newton Bowman ADDRESS Funeral Home
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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..... *W E Edmanston*

Signed.....
Student Embalmer

Licensed Embalmer No. *4791*

P. O. Address *31850 105th St. S. Joplin, 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.