

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

8441

State File No. _____

S. No. 300
v. 10.4.

FILED MAR 10 1953

BIRTH NO. _____ REG. DIST. NO. 336 PRIMARY REG. DIST. NO. 336 Registrar's No. 230

1010

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

1. PLACE OF DEATH a. COUNTY Shannon		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Shannon	
b. CITY (If outside corporate limits, write RURAL and give township) Winona Twp		c. LENGTH OF STAY (In this place) 59 yrs	
c. CITY (If outside corporate limits, write RURAL and give township) Winona		1010	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location) 0	
3. NAME OF DECEASED a. (First) OTIS b. (Middle) _____ c. (Last) NORRIS			4. DATE OF DEATH Feb 23-1953
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Aug. 11-1893
9. AGE (In years last birthday) 59		10. MONTHS 6	11. DAYS 12
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Timber & Logging		11. BIRTHPLACE (City and State or Foreign Country) Winona, Mo.	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Sherman Norris		13b. MOTHER'S MAIDEN NAME Sarah Bland	14. NAME OF HUSBAND OR WIFE Azalee Norris
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.	17. INFORMANT'S SIGNATURE OR NAME Mrs Glenn Thompson ADDRESS Winona, 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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion ANTECEDENT CAUSES DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Hist. of much coronary angina Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4201	
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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 5:15P m., from the causes and on the date stated above.			
23a. SIGNATURE Joseph F. Wilson (Degree or title) Coroner		23b. ADDRESS Shannon county coroner Eminence, Mo.	23c. DATE SIGNED 2/27/53
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 2-26-53	24c. NAME OF CEMETERY OR CREMATORY New	24d. LOCATION (City, town, or county) (State) Winona, Mo.
DATE REC'D BY LOCAL REG. 3-7-53	REGISTRAR'S SIGNATURE Mike Green	25. FUNERAL DIRECTOR'S SIGNATURE 447 ADDRESS Duncan Funeral Home Mtn View, Mo.	

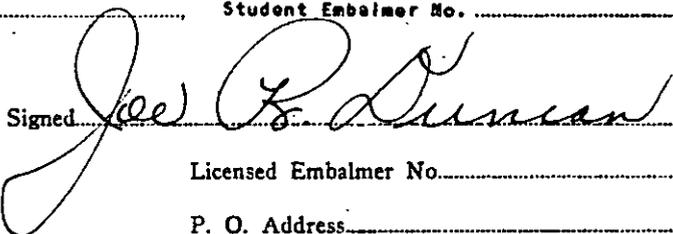
STATEMENT BY LICENSED EMBALMER

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  _____
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.