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FILED APR 4 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **7329**

BIRTH NO. _____ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000** Registrar's No. **316**

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).	
a. COUNTY Buchanan		a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, write RURAL and give town) St. Joseph	c. LENGTH OF STAY (in this place) 1 day	c. CITY OR TOWN Wallace	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION Mo. Methodist Hospital		f. STREET ADDRESS (If rural, give location) General Delivery	

3. NAME OF DECEASED			4. DATE OF DEATH		
a. (First) JOHN	b. (Middle) WESLEY	c. (Last) NORRIS	(Month) March	(Day) 23	(Year) 1955
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Jan. 6, 1868		9. AGE (In years last birthday) 87
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (City and State or Foreign Country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Moses Norris	13b. MOTHER'S MAIDEN NAME Rebecca ?	14. NAME OF HUSBAND OR WIFE Sarah Norris (de)
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Irvin Norris, St. Joseph, 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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH Ukn.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Bronchial Pneumonia		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	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) 4200
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	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 12-18, 1952, to 3-23, 1955 that I last saw the deceased alive on 3-23, 1955, and that death occurred at 6:45P m., from the causes and on the date stated above.

23a. SIGNATURE <i>Irvin Norris</i> (Degree or title) MD	23b. ADDRESS Tootle Building St. Joseph, Mo.	23c. DATE SIGNED 3-23-55
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Mar. 25, 1955	24c. NAME OF CEMETERY OR CREMATORY Judah Cemetery
24d. LOCATION (City, town, or county) (State) Wallace, Missouri		

DATE REC'D BY LOCAL REG. March 28, 1955	REGISTRAR'S SIGNATURE <i>Arthur M. Allison</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>John E. [Signature]</i>	ADDRESS St. Joseph, Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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..

Student.....
Signature of Student Embalmer

Signed.....
John E. Rupp

Licensed Embalmer No. 398

P. O. Address.....
St. Joseph

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.