

S. No. 300
V. 10-48

FILED SEP 28 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **31084**

BIRTH NO. _____		REG. DIST. NO. <u>150</u>		PRIMARY REG. DIST. NO. <u>5572</u>		Registrar's No. <u>161</u>	
1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>JACKSON</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>RURAL PRAIRIE</u>		c. LENGTH OF STAY (in this place) <u>Weeks</u>		c. CITY OR TOWN <u>INDEPENDENCE</u>		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 <u>Jackson County Hosp.</u>				e. STREET ADDRESS (If rural, give location) <u>511 So Osage</u> <u>100^s 1</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Lola</u>			b. (Middle) <u>M.</u>		c. (Last) <u>NORMAN</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>SEPT. 21 1956</u>
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Dec 12, 1875</u>		9. AGE (In years less Birthdays) <u>80</u>	IF UNDER 1 YEAR Months Days	IF UNDER 11 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>O.A.A.</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>H. Scott, Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Milton M. Leaton</u>			13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>William Norman</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. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Lillian Leaton Independence, Mo.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>CERebral thrombosis</u> ANTECEDENT CAUSES DUE TO (b) <u>ARTERIO Sclerosis</u> DUE TO (c) <u>FRACTURE LEFT ARM</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>332XF</u>				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 <u>Aug. 17, 1956</u> , to <u>Sept. 21, 1956</u> , that I last saw the deceased alive on <u>Sept 20, 1956</u> , and that death occurred at <u>9:15 A</u> m., from the causes and on the date stated above.							
23a. SIGNATURE <u>Ronald Norman M.D.</u> (Degree or title)				23b. ADDRESS <u>Independence, Mo.</u>		23c. DATE SIGNED <u>9-21-56</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>9-24-56</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Mound Grove Cem.</u>		24d. LOCATION (City, town, or county) (State) <u>Independence, Mo.</u>		
DATE REC'D BY LOCAL REG. <u>9-22-1956</u>		REGISTRAR'S SIGNATURE <u>D.B. Lanyonford</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Geo. C. Carson & Son's Indep. Mo.</u>			

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

1830

(Licensed Embalmer's Statement on Reverse Side)

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 *Tom D. Markland*

Licensed Embalmer No. *4592*

P. O. Address *Indep M*

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.