

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

9533

FILED APR 8 - 1957

STATE FILE NUMBER

Registration District No. 251 Primary Registration District No. 3048 Registrar's No. 98

Health,  
Welfare  
Public  
Service

300  
1-56,

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

|   |   |   |   |
|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Nodaway</b>   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>Nodaway</b>                          |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Maryville</b>  |   | c. CITY OR TOWN <b>Maryville 0742</b>   |   |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>520 East 6th</b>   |   | d. STREET ADDRESS (If outside, give location) <b>520 East 6th</b>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>JOSEPH</b> Middle <b>RANSON</b> Last <b>NORMAN</b>  |   | 4. DATE OF DEATH<br>Month <b>3</b> Day <b>25</b> Year <b>57</b>   |   |
| 5. SEX <b>Male</b>  | 6. COLOR OR RACE <b>White</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>7/9/62</b>  |
| 9. AGE (In years last birthday) <b>94</b>   |   | IF UNDER 1 YEAR<br>Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>   | IF UNDER 24 HRS.<br>Hours <b>0</b> Min. <b>0</b>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer-retired</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY <b>Own account</b>  | 11. BIRTHPLACE (City and state or country) <b>Afton, Iowa</b>   |
| 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |   | 13. FATHER'S NAME <b>John Norman</b>  |   |
| 14. MOTHER'S MAIDEN NAME <b>Martha Smith</b>  |   | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>   |   |
| 16. SOCIAL SECURITY NO. <b>none</b>   |   | 17. INFORMANT Address <b>Mrs. Harry Strange, Maryville, Mo.</b>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Chronic Myocarditis</b>   |   |   | INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>   |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____  |   |   | <b>4221</b>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n)<br><b>Arteriosclerotic gangrene of foot.</b>   |   |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>2</b> |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) |   |   |
| 20c. TIME OF INJURY<br>Hour _____ Month _____ Day _____ Year _____<br>a. m. _____ p. m. _____   |   |   |   |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  | 20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)   | 20f. CITY, TOWN, OR LOCATION  | COUNTY STATE  |
| 21. I attended the deceased from <b>1955</b> to <b>Mar. 25, 1957</b> and last saw <del>him</del> <sup>her</sup> alive on <b>March 25, 1957</b> .<br>Death occurred at <b>4:15 P.</b> m on the date stated above; and to the best of my knowledge, from the causes stated. |   |   |   |
| 22a. SIGNATURE (Degree or title) <b>H. C. Purnsbee M. D.</b>  |   | 22b. ADDRESS <b>Maryville, Mo.</b>  | 22c. DATE SIGNED <b>3/27/57</b>   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>   | 23b. DATE <b>3/31/57</b>  | 23c. NAME OF CEMETERY OR CREMATORY <b>Burch</b>   | 23d. LOCATION (City, town, or county) (State) <b>Braddyville, Iowa</b>                                  |
| 24. FUNERAL DIRECTOR ADDRESS <b>Price Funeral Home, Maryville, Mo</b>   |   | 25. DATE RECD. BY LOCAL REG. <b>4-6-57</b>  | 26. REGISTRAR'S SIGNATURE <b>Bess Holt</b>  |

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 W. Price*

Licensed Embalmer No. *428*

P. O. Address *Maryville*

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.