

Health,  
& Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-014371  
STATE FILE NUMBER

FILED MAY 9 1958

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2082

S. 300  
1-57

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Kansas City</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Menorah Hosp.</b>		Length of stay in lb <b>life</b>	d. STREET ADDRESS (If outside, give location) <b>5050 Oak</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Howard</b> Middle <b>Lee</b> Last <b>Normand</b>			4. DATE OF DEATH Month <b>April</b> Day <b>22</b> Year <b>1958</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 type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 11, 1946</b>
9. AGE (In years, month, day) <b>11 yrs</b>		IF UNDER 1 YEAR Months <b>11</b> Days <b>0</b>	IF UNDER 24 HRS. 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>child</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>	11. BIRTHPLACE (City and state or country) <b>Kansas City, Missouri</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13a. FATHER'S NAME <b>Leon Normand</b>	
13b. MOTHER'S MAIDEN NAME <b>Gladys Ruth</b>		14. NAME OF HUSBAND OR WIFE <b>---</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 <b>Mr. Leon Normand</b> Address <b>5050 Oak St.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Malignant Neoplasm, Brain</b> <b>(Left Frontal - Temporal) Type</b> <b>undetermined possible astrocytoma</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>---</b> DUE TO (c) <b>---</b>			INTERVAL BETWEEN ONSET AND DEATH <b>0023, 1956</b> <b>1930</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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 Hour <b>---</b> Month <b>---</b> Day <b>---</b> Year <b>---</b> a.m. <b>---</b> p.m. <b>---</b>		20d. INJURY OCCURRED WHILE AT <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>1950</b> to <b>4/22/58</b> and last saw him alive on <b>4/22/58</b> . Death occurred at <b>9:30 AM</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Sidney F. Pakula M.D.</b>		22b. ADDRESS <b>411 Nichols Rd</b>	22c. DATE SIGNED <b>4/23/58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>4-23-1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill</b>	23d. LOCATION (City, town, or county) (State) <b>Kansas City Missouri</b>
24. FUNERAL DIRECTOR ADDRESS <b>Stine &amp; McClure Und. Co. K. C. Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>4-23-58</b>	26. REGISTRAR'S SIGNATURE <b>Neva Marshall</b>

All diseases in Part I must be causally related.

Sidney F. Pakula USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION



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 *J. S. Walters* .....

Licensed Embalmer No. *2244* .....

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