

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 causally related. Coroner cannot certify to a death due to natural causes.

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-023592
STATE FILE NUMBER

FILED JUN 30 1958

318

1003

5884

Registration District No. Primary Registration District No. Registrar's No.

| | | | | | | | |
|---|--|---|---|---|--------------|--|---|
| 1. PLACE OF DEATH a. COUNTY | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST LOUIS</u> | | | | c. CITY OR TOWN <u>OVERLAND 420X</u> | | b. COUNTY <u>ST LOUIS</u> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST LUKES</u> | | | | Length of stay in lb <u>3 DAYS</u> | | d. STREET ADDRESS (If outside, give location) <u>8650 OLDEN</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Bruce</u> Last <u>Norris</u> | | | | 4. DATE OF DEATH Month <u>6</u> Day <u>9</u> Year <u>58</u> | | | |
| 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>9/13/91</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Employee</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>McDonald Aircraft</u> | | 11. BIRTHPLACE (City and state or country) <u>ST LOUIS Mo. 0</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>A. E. NORRIS</u> | | | | 14. MOTHER'S MAIDEN NAME <u>KITTY KIRKMAN</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES W W I</u> | | | | 16. SOCIAL SECURITY NO. <u>498-22-4614</u> | | 17. INFORMANT <u>ALICE NORRIS</u> Address <u>8650 OLDEN</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration pneumonia</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Malnutrition & severe emaciation</u> | | | | | | | <u>9 mos.</u> |
| DUE TO (c) <u>Carcinoma of the stomach</u> | | | | | | | <u>10-11 mos.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Pulmonary emphysema, obstructive, severe</u> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.) <u>151X</u> | | | | |
| 20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ | | | 20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | | | | |
| 20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 20f. CITY, TOWN, OR LOCATION | | COUNTY STATE | | |
| 21. I attended the deceased from <u>6/7/58</u> to <u>6/9/58</u> and last saw her alive on <u>6/9/58</u> Death occurred at <u>3:05</u> P. m. on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE (Degree or title) <u>Horace McEAT M. D.</u> | | | | 22b. ADDRESS <u>1328 McCutcheon Richmond Heights 17 mo</u> | | 22c. DATE SIGNED <u>6/10/58</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 23b. DATE <u>6-12-58</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Valhalla Cemetery</u> | | 23d. LOCATION (City, town, or county) (State) <u>St. Louis Co., Mo.</u> | |
| 24. FUNERAL DIRECTOR <u>EARL HILLEMAN</u> ADDRESS <u>9709 LACKLAND RD.</u> | | | | 25. DATE RECD. BY LOCAL REG. <u>JUN 10 58</u> | | 26. REGISTRAR'S SIGNATURE <u>J. Carl Smith, M.D.</u> <u>S.P.</u> | |

(Licensed Embolmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

Corrected by 11/8/58 TABRIF

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 *Earl F. Hilleman*

Licensed Embalmer No. *350*

P. O. Address *Overland*

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.