

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-001464  
STATE FILE NUMBER

FILED JAN 21 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 98

300  
-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>Independence</b> <b>7005</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Trinity Hosp.</b>		Length of stay in lb <b>1 week</b>	d. STREET ADDRESS (If outside, give location) <b>1919 Scott</b>
3. NAME OF DECEASED (Type or print) First <b>BILL</b> Middle <b>NORMAN</b> Last <b>NORMAN</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>6,</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 4, 1918</b>
9. AGE (In years last birthday) <b>40</b>		IF UNDER 1 YEAR Months <b>0</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>Shipping Foreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gordon Johnson &amp; Co.</b>	11. BIRTHPLACE (City and state or country) <b>Warrensburg, Mo.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>James Walter Norman</b>	
13b. MOTHER'S MAIDEN NAME <b>Edna E. Smethers</b>		14. NAME OF HUSBAND OR WIFE <b>Leah Norman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>568-07-3133</b>	17. INFORMANT <b>Leah Norman, 1919 Scott, Indep., Mo.</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>Relational Bacterial Bronchopneumonia</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Cerebral Edema</b>			<b>4 days</b>
DUE TO (c) <b>Chronic Renal Disease - Cerebral</b>			<b>6-12 mo.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, but not related to the terminal disease condition given in PART I (a) <b>Alcoholism 2 mo 5</b>			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>4:00 A</b> Month, Day, Year			
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 Death occurred at <b>4:00 A</b> <b>Jan 3, 1959</b> to <b>Jan 6, 59</b> and last saw him alive on <b>Jan 5, 1959</b>		m of the date stated above; and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <b>Edw. H. Fischer M.D.</b>		22b. ADDRESS <b>306 E 21st NKC MO</b>	22c. DATE SIGNED <b>1-7-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>1-8-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Floral Hills Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Kansas City, Mo.</b>
24. FUNERAL DIRECTOR <b>Geo. C. Carson &amp; Sons, Indep., Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>1-7-59</b>	26. REGISTRAR'S SIGNATURE <b>Neve Marshall</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

Edw. H. Fischer

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  .....

Licensed Embalmer No. 4697 .....  
P. O. Address Indy 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.