

FILED FEB 16 1959

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-005194

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 200 Registrar's No. 136A

300
1-57

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Fair Grove</u> c. 390
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Handley Hosp.</u>		Length of stay in lb <u>5 days</u>	d. STREET ADDRESS (If outside, give location) <u>-----</u>
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Nora</u> Middle <u>---</u> Last <u>Norton</u>			4. DATE OF DEATH Month <u>Feb.</u> Day <u>6</u> Year <u>1959</u>		
---	--	--	---	--	--

5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</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>July 12, 1884</u>	9. AGE (In years last birthday) <u>74</u>	IF UNDER 1 YEAR Months <u>---</u> Days <u>---</u>	IF UNDER 24 HRS. Hours <u>---</u> Min. <u>---</u>
-------------------------	----------------------------------	---	--	---	--	--

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>Home</u>	11. BIRTHPLACE (City and state or country) <u>Webster County, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
---	--	--	---

13a. FATHER'S NAME <u>James R. Tracy</u>	13b. MOTHER'S MAIDEN NAME <u>Julia Wommack</u>	14. NAME OF HUSBAND OR WIFE <u>W. L. Norton</u>
---	---	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT Address <u>W. L. Norton, Fair Grove, Missouri</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>Uremia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
DUE TO (b) <u>Possible Ca Calcium</u>		
DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>1530</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.)
---	--

20c. TIME OF INJURY Hour _____ o.m. _____ p.m. _____	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____
---	--	--

20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____
---	--

21. I attended the deceased from February 1 to February 6 and last saw her alive on Feb. 6, 1959
Death occurred at 4:00 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Joseph D. Allen M.D.</u>	22b. ADDRESS <u>Springfield, Mo.</u>	22c. DATE SIGNED <u>2-10-'59</u>
---	---	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>2-8-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>near Fair Grove, Missouri</u>
--	------------------------------	---	---

24. FUNERAL DIRECTOR <u>Rex Rainey--Springfield, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>2-13-59</u>	26. REGISTRAR'S SIGNATURE <u>Effie G. Melton</u>
---	--	---

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

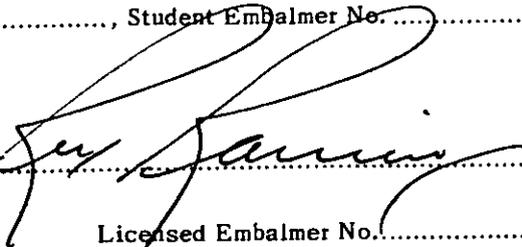
All diseases in Part I must be causally related.

MS
MAR 6
(1971)

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.

P. O. Address

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.