

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-013470

STATE FILE NUMBER

2039

Registration District No. 149

Primary Registration District No. 1002

Registrar's No.

FILED MAY 13 1959

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1-57

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		c. CITY OR TOWN <u>Kansas City</u>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Gen. Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>325 W 11th</u>	
Length of stay in lb <u>20 yrs.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>EFFIE</u> Middle <u>Estella</u> Last <u>NORRIS</u>			4. DATE OF DEATH Month <u>4</u> Day <u>21</u> Year <u>59</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>12-2-1871</u>		9. AGE (In years birthday) <u>87</u> MONTHS <u>1</u> DAYS <u>1</u> IF UNDER 24 HRS. Hours <u>1</u> Min. <u>1</u>	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country)	12. CITIZEN OF WHAT COUNTRY?
<u>Practical Nurse</u>	<u>Physicians Offices Blue Springs, Nebraska</u>	<u>Blue Springs, Nebraska</u>	<u>U.S.A.</u>

13a. FATHER'S NAME <u>Christchristianson Mowry</u>	13b. MOTHER'S MAIDEN NAME <u>Lucindia Harpster</u>	14. NAME OF HUSBAND OR WIFE <u>Mark Norris</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Mrs. Nelle Johnston</u> Address <u>K.C., Mo. 325 West 11th St.</u>
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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>Mild Cardio Infarction</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____		
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>4201</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 _____ 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 4-15-59 to 4-21-59 and last saw ^{her} _{him} alive on 4-21-59. Death occurred at 4:50 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Abraham Gelpert</u> (Degree or title)	22b. ADDRESS <u>Gen. Hospital</u>	22c. DATE SIGNED <u>4-22-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>4-24-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mount Calvary Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Kansas City, Kansas</u>
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24. FUNERAL DIRECTOR <u>Weilert Funeral Homes (S) K.C., Mo.</u> ADDRESS	25. DATE RECD. BY LOCAL REG. <u>4-23-59</u>	26. REGISTRAR'S SIGNATURE <u>Meva Minchall</u>
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Abraham Gelpert in MUSE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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.

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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 B. E. Weir

Licensed Embalmer No. 4075
P. O. Address L. C. 8 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.