

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JUL 30 1959

59-027016

STATE FILE NUMBER

Registration District No. Primary Registration District No. Registrar No. 6765

DED

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY CRAWFORD			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN 915 N GRAND ST LOUIS MO			Length of stay in 1b 33 DAYS	c. CITY OR TOWN CUBA		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VETS ADMIN HOSPITAL			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last EGBERT W. NORTON				4. DATE OF DEATH Month Day Year JULY 19 1959			
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 6/30/96	9. AGE (last birthday) 63	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Operator		10b. KIND OF BUSINESS OR INDUSTRY Filling Station		11. BIRTHPLACE (City and state or country) LOUISIANA, MISSOURI		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME WILLIAM NORTON			13b. MOTHER'S MAIDEN NAME MABEL BLONDELL		14. NAME OF HUSBAND OR WIFE ELSIE NORTON		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW I		16. SOCIAL SECURITY NO. 498188013		17. INFORMANT Address VA HOSP RECORDS 915 N GRAND ST LOUIS MO			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) LOBAR PNEUMONIA DUE TO (c) THROMBOPHLEBITIS							INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN UNKNOWN
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
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 a.m. p.m. Month, Day, Year							
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. <input checked="" type="checkbox"/> attended the deceased from 6/16/59 to 7/19/59 and last saw him alive on 7/19/59 Death occurred at 6:50 PM on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE R. G. CHANDLER (Degree or title) M.D.				22b. ADDRESS VAH, ST LOUIS, MISSOURI		22c. DATE SIGNED 7/20/59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 7-20-59	23c. NAME OF CEMETERY OR CREMATORY Local		23d. LOCATION (City, town, or county) Cuba, Missouri.		23e. (State)	
24. FUNERAL DIRECTOR Albert H. Hoppe, Inc., 4700 Washington			25. DATE RECD. BY LOCAL REG. JUL 20 59		26. REGISTRAR'S SIGNATURE Roan Smith. M.D. m d e		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed J. W. Dumbley  
Licensed Embalmer No. 365

P. O. Address H. Lewis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.