

**DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-029240**

FILED VS SEP 4 1959

149

Primary Registration District No. 1002

Registrar's No.

4014

STATE FILE NUMBER

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Jackson</b>			<b>2. USUAL RESIDENCE</b> (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>		Length of stay in 1b <b>5 Yrs.</b>	c. CITY OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Research Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>4541 Main</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>JAMES</b> Middle <b>ELIJAH</b> Last <b>NORTON</b>			<b>4. DATE OF DEATH</b> Month <b>August</b> Day <b>18,</b> Year <b>1959</b>			
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input checked="" type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>July 17, 1874</b>	<b>9. AGE (last birthday)</b> <b>85</b>	<b>IF UNDER 1 YEAR</b> Months Days Hours Min. <b>IF UNDER 24 HR</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (City and state or country) <b>Mercer Co., Missouri</b>	<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U. S. A.</b>	
<b>13a. FATHER'S NAME</b> <b>George Norton</b>		<b>13b. MOTHER'S MAIDEN NAME</b> <b>Amanda Thompson</b>		<b>14. NAME OF HUSBAND OR WIFE</b> <b>Annie B. Norton</b>		
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	<b>16. SOCIAL SECURITY NO.</b> <b>None</b>	<b>17. INFORMANT</b> <b>Miss Ruby Norton</b>		Address <b>Kansas City, Mo.</b>		
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro Vascular Thrombosis</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>arteriosclerosis</b> DUE TO (c) <b>Smilets</b>					INTERVAL BETWEEN ONSET AND DEATH <b>8 hrs</b>	
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		
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)				
<b>20c. TIME OF INJURY</b> Hour : Month, Day, Year a.m. p.m.	<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>20f. CITY, TOWN, OR LOCATION</b>	<b>COUNTY</b>	<b>STATE</b>	
<b>21. I attended the deceased from</b> <b>July 7 1954</b> to <b>8/18/59</b> and last saw her/him alive on <b>8/17/59</b> Death occurred at <b>2430 Oak 8/18/59</b> on the date stated above, and to the best of my knowledge, from the causes stated.						
<b>22a. SIGNATURE</b> <i>[Signature]</i> (Degree or title)			<b>22b. ADDRESS</b> <b>Professional Office of Spickard, Missouri</b>		<b>22c. DATE SIGNED</b> <b>8/18/59</b>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Removal</b>	<b>23b. DATE</b> <b>8-18-59</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b>		<b>23d. LOCATION</b> (City, town, or county) (State) <b>Spickard, Missouri</b>		
<b>24. FUNERAL DIRECTOR</b> <b>Freeman Mortuary</b>		ADDRESS <b>Kansas City, Mo.</b>		<b>25. DATE RECD. BY LOCAL REG.</b> <b>8-18-59</b>	<b>26. REGISTRAR'S SIGNATURE</b> <i>[Signature]</i>	

DOCUMENT

BY AFFIDAVIT OF Robert C. McClellan, M.D. MEDICAL CERTIFICATION

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed

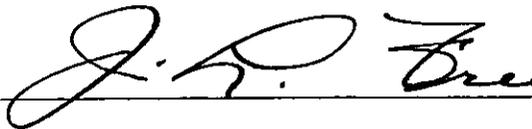
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed



Licensed Embalmer No. 29

P. O. Address F. O. 1

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