URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

59-040261

FILED VS DEC 7 1959

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5583

ENDED

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City — Length of stay in 1b 15 Yrs
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 3944 Charlotte — Inside Limits Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Jackson
c. CITY OR TOWN Kansas City — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 3944 Charlotte — Reside on Farm Yes ☒ No ☒

3. NAME OF DECEASED (Type or print) First ANTHONY Middle LEONARD Last NORRIS

4. DATE OF DEATH Month November Day 17 Year 1959

5. SEX Male
6. COLOR OR RACE White
7. Married ☐ Never Married ☐ Widowed ☐ Divorced ☒
8. DATE OF BIRTH 7/7/1901
9. AGE (last birthday) 58 — 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) Sheet Metal Worker
10b. KIND OF BUSINESS OR INDUSTRY United Air Condition
11. BIRTHPLACE (City and state or country) Bath County Kentucky
12. CITIZEN OF WHAT COUNTRY USA

13a. FATHER'S NAME Dave Norris
13b. MOTHER'S MAIDEN NAME Devara Lathrem
14. NAME OF HUSBAND OR WIFE ~~Nannie Turner~~

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 493-18-5433
17. INFORMANT Mrs Dave Norris Address 3944 Charlotte K C 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) Cardiac Decompensation
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Myocardial Degeneration
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH

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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 12:05 A.m. 11/17/59, to 12:30 A.m. 11/17/59 and last saw ~~her~~ him alive on 11-17-59
Death occurred at about 5:00 A.m. 11/17/59 m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Edw. H. Bird - D.O.
22b. ADDRESS 2444 E. 67 Terr.
22c. DATE SIGNED 11/18/59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 11/19/59
23c. NAME OF CEMETERY OR CREMATORY Pleasant Ridge Cemetery
23d. LOCATION (City, town, or county) (State) Weston Missouri

24. FUNERAL DIRECTOR ADDRESS Vaughn Funeral Home Weston Missouri
25. DATE RECD. BY LOCAL REG. 11-19-59
26. REGISTRAR'S SIGNATURE Neva Minshall

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF Edw. H. Bird

STATEMENT BY LICENSED EMBALMER

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

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed Thomas A. Shiel

Signature of Student Embalmer

Licensed Embalmer No. 4935

P. O. Address K. C. Mo.

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