

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-003875

FILED VS FEB 5 1960

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's **2 888** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS</b>	Length of stay in 1b <b>19 YEARS</b>	c. CITY OR TOWN <b>ST. LOUIS</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>ST. JOHN'S HOSP.</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>1200 HICKORY ST. APT. 121</b>	Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>ERNEST</b> Middle <b>N.</b> Last <b>NORRIS JR.</b>	4. DATE OF DEATH Month <b>JANUARY</b> Day <b>23</b> Year <b>1960</b>
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5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>10-29-1939</b>	9. AGE (last birthday) <b>26</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TRUCK DRIVER</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>AUTO</b>	11. BIRTHPLACE (City and state or country) <b>GILLESPIE, ILLINOIS</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>ERNEST NORRIS, SR.</b>	13b. MOTHER'S MAIDEN NAME <b>BESSIE WRIGHT</b>	14. NAME OF HUSBAND OR WIFE <b>IMOGENE NORRIS</b>
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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) <b>NO</b>	16. SOCIAL SECURITY NO. <b>NONE</b>	17. INFORMANT Address <b>MRS. IMOGENE NORRIS, 1200 HICKORY ST.</b>
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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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	<b>Cerebral Hemorrhage</b>	<b>3 hours</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Platelet deficiency</b>	
	DUE TO (c) <b>Acute Monocytic leukemia</b>	<b>2 years</b>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>204.2</b>	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
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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.) <b>204.2</b>
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year
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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 _____
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21. I attended the deceased from **Jan 1959** to **Jan. 23, 1960** and last saw <sup>her</sup>him alive on **Jan 23, 1960**  
Death occurred at **10<sup>th</sup>** p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>John W. Winter M.D.</b> (Degree or title)	22b. ADDRESS <b>307 S. Euclid, St. Louis, Mo</b>	22c. DATE SIGNED <b>1/25/60</b> (State)
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>JAN. 29, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>FRIDENS CEMETORY</b>	23d. LOCATION (City, town, or county) <b>MISSOURI</b>
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24. FUNERAL DIRECTOR <b>STOCK MORTUARY, 2117 E. GRAND ST.</b> ADDRESS	25. DATE RECD. BY LOCAL REG. <b>JAN 26 1960</b>	26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>
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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 me

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

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*Paul A. Wadley*

Licensed Embalmer No. 4787

P. O. Address

*Atlanta, Ga*

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.