

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-019067

Dr. Hanss FILED VS MAY 23 1960

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 576 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>GREENE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>GREENE</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>SPRINGFIELD</b>		Length of stay in 1b <b>59 YRS.</b>	c. CITY OR TOWN <b>SPRINGFIELD</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>BURGE HOSP.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>2029 COLLEGE</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>LEONA</b> Middle <b>NORTON</b> Last <b>NORTON</b>	4. DATE OF DEATH Month <b>MAY</b> Day <b>16</b> Year <b>1960</b>
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5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</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>8/5/00</b>	9. AGE (last birthday) <b>59</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>HOUSEWIFE</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>STRAFFORD, MISSOURI</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
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13a. FATHER'S NAME <b>PARIS BRAKE</b>	13b. MOTHER'S MAIDEN NAME <b>MARTHA SMITH</b>	14. NAME OF HUSBAND OR WIFE <b>HENRY NORTON</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>546-28-9948</b>	17. INFORMANT Address <b>HENRY NORTON, SPRINGFIELD, MO.</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: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b>		INTERVAL BETWEEN ONSET AND DEATH <b>18 hrs.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Arteriosclerotic Heart Disease</b> <b>Dev. yrs.</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) <b>chronic glomerulo-nephritis</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 checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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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 checked="" 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 **2-8-60** to **5-16-60** and last saw her alive on **5-16-60**  
Death occurred at **10:45 A.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>H. D. Hanss</b>	22b. ADDRESS <b>Springfield, Mo.</b>	22c. DATE SIGNED <b>5-17-60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>5/19/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>DANFORTH CEMETERY</b>	23d. LOCATION (City, town, or county) (State) <b>NEAR, SPRINGFIELD, MO.</b>
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24. FUNERAL DIRECTOR ADDRESS <b>H. H. LOHMEYER FUNERAL HOME SPRINGFIELD, MO.</b>	25. DATE RECD. BY LOCAL REG. <b>5-18-60</b>	26. REGISTRAR'S SIGNATURE <b>Effie G. Melton</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 \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

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

Signed AK McCann

Licensed Embalmer No. 2727

P. O. Address Apex, N.C.

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.