

R.I. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS OCT 24 1960

-60-040690
STATE FILE NUMBER

Registration District No. 324 Primary Registration District No. 3072 Registrar's No. 186

DED

1. PLACE OF DEATH a. COUNTY <u>Saline</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Saline</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Marshall</u>	Length of stay in 1b <u>6 days</u>	c. CITY OR TOWN <u>Marshall</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Fitzgibbon</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>421 N. Odell</u>
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>GEORGE</u> Middle <u>EDWARD</u> Last <u>NORVELL</u>			4. DATE OF DEATH Month <u>Oct.</u> Day <u>18,</u> Year <u>1960</u>	
---	--	--	---	--

5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9-21-1879</u>	9. AGE (last birthday) <u>81</u>	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) <u>Barber</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Barber Shop</u>	11. BIRTHPLACE (City and state or country) <u>New Frankfurt Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
---	--	---	---

13a. FATHER'S NAME <u>Frank H. Norvell</u>	13b. MOTHER'S MAIDEN NAME <u>Annie Horwoker</u>	14. NAME OF HUSBAND OR WIFE <u>Anna R. Norvell</u>
--	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>448-26-2988</u>	17. INFORMANT Address <u>Mrs Geo. E. Norvell Marshall, Mo</u>
--	--	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Chronic Pyelo nephritis</u>	<u>6 Mo. 1 yr</u>
	DUE TO (c)	

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"/> N. <input type="checkbox"/> Unknown
---	--

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.)
--	---	--

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. I attended the deceased from <u>July 19, 1960</u> to <u>Oct 18 - 60</u> and last saw <u>her</u> live on <u>Oct 18 - 60</u> Death occurred at <u>10:00 A.m</u> on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>S. K. Krummel D.M.S.</u>	22b. ADDRESS <u>Marshall, MO</u>	22c. DATE SIGNED <u>10-20-60</u>
--	----------------------------------	----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Oct. 20, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>William Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>William Mo</u>
---	--------------------------------	--	---

24. FUNERAL DIRECTOR ADDRESS <u>Harry Hershberg Marshall, Mo</u>	25. DATE RECD. BY LOCAL REG. <u>10-20-60</u>	26. REGISTRAR'S SIGNATURE <u>Cecil G. Read</u>
--	--	--

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 _____, Student Embalmer No. _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Harry Hersherberg

Licensed Embalmer No. 435

P. O. Address Marshall

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

done to body