SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

TMENT OF PUBLIC HEALTH AND WELFARE

61-024835
STATE FILE NUMBER

AMENDED

Registration District No. 136 Primary Registration District No. 2000 Registrar's No. 730A

FILED AUG 14 1961

DATE AMENDED | INSTEAD OF | SHOULD READ | ITEM NO. | BY AFFIDAVIT OF | DOCUMENT

1. PLACE OF DEATH
a. COUNTY: Greene
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Springfield — Length of stay in 1b: Life
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: St. John's Hosp. — Inside Limits: Yes # No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri COUNTY: Greene
c. CITY OR TOWN: Brookline — Inside Limits: Yes ☐ No #
d. STREET ADDRESS: Missouri (If outside, give location) — Reside on Farm: Yes # ☐ No ☐

3. NAME OF DECEASED (Type or print): First: George Middle: J. Last: Norman
4. DATE OF DEATH: Month: August Day: 1 Year: 1961
5. SEX: Male
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed # Divorced ☐
8. DATE OF BIRTH: 1-6-1872
9. AGE (last birthday): 89 — 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): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Farm
11. BIRTHPLACE (City and state or country): Missouri
12. CITIZEN OF WHAT COUNTRY: U. S. A.
13a. FATHER'S NAME: Milford Norman
13b. MOTHER'S MAIDEN NAME: Mary O. Perkins
14. NAME OF HUSBAND OR WIFE: Stella Jane Norman, (Deceased)
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
17. INFORMANT: Eldon Norman, Address: Republic, Missouri

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 16 hours
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Cerebral Arteriosclerosis
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Carcinoma of Prostate
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 7/31/61 to 8/1/61 and last saw him alive on 8/1/61
Death occurred at 9:40 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Harold W. Lurie, M.D.
22b. ADDRESS: 600 S. Glenstone Springfield, Mo.
22c. DATE SIGNED: 8/3/61

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 8-3-1961
23c. NAME OF CEMETERY OR CREMATORY: Brookline Cemetery
23d. LOCATION (City, town, or county) (State): Brookline, Missouri

24. FUNERAL DIRECTOR: Rex Rainey ADDRESS: Springfield, Missouri
25. DATE RECD. BY LOCAL REG.: 8-10-61
26. REGISTRAR'S SIGNATURE: Effie E. Meeter

(Licensed Embalmer's Statement on Reverse Side)

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 Alex Dainey

Licensed Embalmer No. 3312

P. O. Address Springfield, Mo

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.