

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-032234

STATE FILE NUMBER

Registration District No. 72 Primary Registration District No. 4134 Registrar's No. 164

AMENDED

FILED OCT 2 1961

1. PLACE OF DEATH a. COUNTY <u>Clay</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Platte</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Smithville</u>		Length of stay in 1b <u>one week</u>	c. CITY OR TOWN <u>Tracy</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Smithville Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>Claude</u> Last <u>Norris</u>			4. DATE OF DEATH Month <u>9</u> Day <u>18</u> Year <u>1961</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>6-22-1886</u>
9. AGE (last birthday) <u>75</u>		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tobacco Farmer</u>	11. BIRTHPLACE (City and state or country) <u>Platte County</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>John Henry Norris</u>	
13b. MOTHER'S MAIDEN NAME <u>Elsie Catherine Davis</u>		14. NAME OF HUSBAND OR WIFE <u>Martha Ann Norris</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>		17. INFORMANT Address <u>Elmer Norris Platte City, 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>Myocardial Infarction</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>7 da</u> <u>5+ yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Cerebral Thrombosis</u>			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
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>Sept 1955</u> to <u>Sept 18, 1961</u> and last saw <u>her</u> alive on <u>Sept 18, 1961</u> Death occurred at <u>5:15 p</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>D R Chiles</u> (Degree or title)		22b. ADDRESS <u>Smithville, Mo.</u>	22c. DATE SIGNED <u>9-20-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>9-20-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Ridge Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Weston, Missouri</u>
24. FUNERAL DIRECTOR <u>Vaughn Funeral Home Weston, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>9-20-61</u>	26. REGISTRAR'S SIGNATURE <u>Marquerite Hudgens</u>

(Licensed Embalmer's Statement on Reverse Side)

AMENDED
 DATE AMENDED
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 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 Robert D. Braun, Student Embalmer No. 695

working under my personal supervision.

Student Robert D. Braun
Signature of Student Embalmer

Signed

W. R. Vaughn

Licensed Embalmer No.

4023

P. O. Address

Weston, Md

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.