

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

62-045995  
STATE FILE NUMBER

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 1467

DO NOT WRITE ON THIS STUB

AMENDED

FILED JAN 3 1962

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>St. Joseph</b>		c. CITY OR TOWN <b>Kansas City</b>	
Length of stay in lb OR <b>44 yrs. 8 mo. 9 days</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>State Hospital #2</b>		d. STREET ADDRESS (If outside, give location) <b>828 Cornhill</b>	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CORA</b> Middle <b>NORTON</b> Last <b>NORTON</b>		4. DATE OF DEATH Month <b>December</b> Day <b>25</b> Year <b>1962</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>1890</b>
9. AGE (last birthday) <b>72</b>		IF UNDER 1 YEAR Months <b>72</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	IF UNDER 24 HR Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Elmira, Mo.</b>
12. CITIZEN OF WHAT COUNTRY <b>USA</b>		13a. FATHER'S NAME <b>E. J. Norton</b>	
13b. MOTHER'S MAIDEN NAME <b>Eliza J. Munson</b>		14. NAME OF HUSBAND OR WIFE <b>none</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, <del>no</del> or unknown) <b>none</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT Address <b>State Hosp. #2 Records, St. Joseph, Mo.</b>		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 (thrombosis)</b>	
DUE TO (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>Schizophrenic reaction Hebephrenic type</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	
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 <b>March 16, 1918</b> to <b>Dec. 25, 1962</b> and last saw her/him alive on <b>Dec. 24, 1962</b>		Death occurred at <b>7:30 p.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <b>Charles M. Clark M.D.</b>		22b. ADDRESS <b>STATE HOSP #2 St. Joseph Mo</b>	
22c. DATE SIGNED <b>12-25-62</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>	
23b. DATE <b>12/27/1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Kirksville Missouri</b>	
23d. LOCATION (City, town, or county) (State)		24. FUNERAL DIRECTOR ADDRESS <b>Hester-Bauman St. Joseph, Mo.</b>	
25. DATE RECD. BY LOCAL REG. <b>Dec. 28, 1962</b>		26. REGISTRAR'S SIGNATURE <b>Mrs. Clark Goodell</b>	

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

BY AFFIDAVIT OF **C.M. Clark, Medical Certification**

VS 300 Rev. 4/59  
15117  
27000  
3  
4 1  
5 0  
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7 0  
8 2  
9 420.1  
10  
11  
1293-0  
131-0

USE BLACK INK OR TYPEWRITER RIBBON

Permit issued 12/27/62

**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 Eugene Wood

Licensed Embalmer No. 3804  
P. O. Address 319 So 10th St Joseph, 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.