

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
FILED VS OCT 23 1959

59-036319

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4901

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 1b 40 yrs.	c. CITY OR TOWN Kansas City
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Lukes Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Montrose Hotel 40th & Main
		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) LOUISA MAY NORCROSS	First LOUISA Middle MAY Last NORCROSS	4. DATE OF DEATH October 11, 1959
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5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9-2-1883	9. AGE (last birthday) 76	10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	11. IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Fairfax, Missouri	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME U. P. Judson	13b. MOTHER'S MAIDEN NAME Anna Rogge	14. NAME OF HUSBAND OR WIFE Clarence D. Norcross
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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) no	16. SOCIAL SECURITY NO. unk.	17. INFORMANT Address Clarence D. Norcross Montrose Hotel
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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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) unknown bleeding complete		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Autopsy Report	
	DUE TO (c) pulmonary embolism	
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"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) pedestrian struck by car
20c. TIME OF INJURY Hour <input type="checkbox"/> s.m. <input type="checkbox"/> p.m. <input type="checkbox"/> 10-1-59		

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.) 40th & main	20f. CITY, TOWN, OR LOCATION Kansas City	COUNTY Jackson	STATE Mo.
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE Meghan Owens Corcoran	(Degree or title)	22b. ADDRESS 1034 Prairie Blvd	22c. DATE SIGNED 10-12-59
23a. BURIAL, CREATION, REMOVAL (Specify) Removal	23b. DATE Oct. 14, 1959	23c. NAME OF CEMETERY OR CREMATORY Clarksdale Cemetery	23d. LOCATION (City, town, or county) (State) Clarksdale, Missouri
24. FUNERAL DIRECTOR Freeman Mortuary	ADDRESS Kansas City, Mo.	25. DATE RECD. BY LOCAL REG. 10-12-59	26. REGISTRAR'S SIGNATURE Neva Marshall

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF
Hugh H. Owens

An H. H. Assoc.
Rialto Bldg

OCT 25 1962

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.