

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-009663

DO NOT WRITE
ON THIS STUD

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

2588

STATE FILE NUMBER

FILED MAR 14 1963

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN Wellston	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Missouri Baptist Hospital		d. STREET ADDRESS (If outside, give location) 1528a Wellston Pl.	
3. NAME OF DECEASED (Type or print) First Middle Last Norah Wood		4. DATE OF DEATH Month Day Year March 4, 1963	
5. SEX Female	6. COLOR OR RACE White	7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐	8. DATE OF BIRTH 8/14/1891
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and state or country) St. Francois Co., Mo.
13a. FATHER'S NAME John Kennon		13b. MOTHER'S MAIDEN NAME Margaret (Unknown)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) No		17. INFORMANT Mrs. A.W. Byington, 1539 Valley Ave.	
18. CAUSE OF DEATH (Enter only one cause) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac insufficiency Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerotic heart disease DUE TO (c) 420.0 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Bronchopneumonia			INTERVAL BETWEEN ONSET AND DEATH 5 mos 8 yrs
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐		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		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
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.)	
21. I attended the deceased from 35 Feb '55 to 4 Mar '63 and last saw her alive on 4 Mar 1963 Death occurred at 5:30 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) T. S. Strake, M.D.		22b. ADDRESS 117 N. Taylor St. L. 8 Mo	
22c. DATE SIGNED 5 Mar '63		23d. LOCATION (City, town, or county) (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 3-7-63	
23c. NAME OF CEMETERY OR CREMATORY Fredericktown Cemetery		23d. LOCATION (City, town, or county) Fredericktown, Mo.	
24. FUNERAL DIRECTOR Caldwell Funeral Home, Flat River, Mo.		25. DATE RECD. BY LOCAL REG. MAR 6 1963	
26. REGISTRAR'S SIGNATURE Dean Smith, M.D.			

USE BLACK INK
OR
TYPEWRITER RIBBON

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. 3957

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.