

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

PLACE OF DEATH
 County Nodaway
 Township _____ Registration District No. 624 File No. 5554
 or _____
 Village Hopkins Primary Registration District No. 4375 Registered No. _____
 or _____
 City MO. (NO. _____) St. _____ Ward _____

FULL NAME Amos A. Norton

[If death occurred in a hospital or institution, give its NAME instead of street and number]

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>M</u>	COLOR OR RACE <u>W.</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>Widower</u> <small>(Write the word)</small>
DATE OF BIRTH <u>July 25 1831</u> <small>(Month) (Day) (Year)</small>		
AGE <u>82</u> yrs. <u>7</u> mos. <u>-</u> ds.		IF LESS than 1 day, <u>-</u> hrs. or <u>-</u> min.?
OCCUPATION (a) Trade, profession, or particular kind of work _____ (b) General nature of industry, business, or establishment in which employed (or employer) _____		
BIRTHPLACE (City or town, State or foreign country) <u>Maine</u>		
PARENTS	NAME OF FATHER <u>A. H. Norton</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Maine</u>	
	MAIDEN NAME OF MOTHER <u>Norton</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Maine</u>	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feb 25 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Feb 20, 1914, to Feb 24, 1914, that I last saw him alive on Feb 24, 1914, and that death occurred, on the date stated above, at 5:45 A.M.

The CAUSE OF DEATH* was as follows:
Pneumonia

(Duration) _____ yrs. _____ mos. 4 ds.

Contributory Bright's disease
(SECONDARY) (Duration) 4 yrs. _____ mos. _____ ds.

(Signed) D. A. Sargent M. D.
Feb 25 1914 (Address) Hopkins Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
 At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.
 Where was disease contracted If not at place of death? _____
 Former or usual residence _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Paul Layfle
 (ADDRESS) Hopkins Mo.

Filed 2/26 1914. C. W. Kirk
R. K. REGISTRAR

PLACE OF BURIAL OR REMOVAL <u>Hopkins, Mo.</u>	DATE OF BURIAL <u>2/26</u> 1914
UNDERTAKER <u>O. H. Saylor</u>	ADDRESS <u>Hopkins Mo.</u>

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sar-*

coma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septichaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)



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MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

County Madison Registration District No. 624 File No. _____
 Township Hopkins or _____ Primary Registration District No. 4375 Registered No. _____
 Village _____ or _____ City _____ (NO. _____) St. _____ Ward _____

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Amos. A. Norton

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH	
SEX <u>M</u>	COLOR OR RACE <u>W</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>W</u> <small>(If wife the word)</small>	DATE OF DEATH <u>4/25</u> , 191 <u>4</u> <small>(Month) (Day) (Year)</small>	
DATE OF BIRTH _____, _____, 191____ <small>(Month) (Day) (Year)</small>			I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I first saw _____, 191____, and that death occurred, on the date stated above, at <u>5th</u> a.m.	
AGE _____ yrs. _____ mos. _____ ds.		If LESS than 1 day, _____ hrs. or _____ min.	The CAUSE OF DEATH* was as follows: <u>Pneumonia, Bronchial</u>	
OCCUPATION (a) Trade, profession, or particular kind of work _____ (b) General nature of industry, business, or establishment in which employed (or, employer) _____			(Duration) _____ yrs. _____ mos. _____ ds.	
BIRTHPLACE (City or town, State or foreign country) _____			Contributory <u>Bright's Kds</u> (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.	
PARENTS	NAME OF FATHER _____		(Signed) <u>D. A. Sargent</u> M. D.	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) _____		<u>7/25</u> 191 <u>4</u> (Address) <u>Hopkins Mo</u>	
	MAIDEN NAME OF MOTHER _____		*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) _____		LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.	
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) _____ (ADDRESS) _____			Where was disease contracted If not at place of death? _____ Former or usual residence _____	
Filed <u>4/26</u> 191 <u>4</u>			PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____ 191____	
REGISTRAR			UNDERTAKER _____ ADDRESS _____	

Satisfactory Information Supplied.
 SUPPLEMENTARY INFORMATION SUPPLIED.
 Satisfactory Information Supplied.

Satisfactory Information Supplied.

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