PLACE OF DEATH

County Macon

Township Ley Mile

or

Village

or

City (NO. , St.; Ward)

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

Registration District No. 1072 File No. 9742

Primary Registration District No. 5716 Registered No. 1

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

FULL NAME Chas A Norton

PERSONAL AND STATISTICAL PARTICULARS

SEX Male

COLOR OR RACE White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Widower

DATE OF BIRTH Mar 18, 1830 (Month) (Day) (Year)

AGE 87 yrs. 11 mos. 26 ds. If LESS than 1 day, hrs. or min.?

OCCUPATION
(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) 131 162

BIRTHPLACE (City or town, State or foreign country) Buffalo N. Y.

PARENTS

NAME OF FATHER Chas N Norton

BIRTHPLACE OF FATHER (City or town, State or foreign country) Vermont

MAIDEN NAME OF MOTHER Anna Knapp

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Conn.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lee Norton

(ADDRESS) Macon Mo R 2

Filed Mar 20, 1918. Geo E Mapes REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Mch 14, 1918 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Mch 7, 1918, to Mch 14, 1918, that I last saw him alive on Mch 7, 1918, and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis Pheumonitis

(Duration) 10 yrs. mos. ds.

Contributory (SECONDARY) To age

(Duration) 10 yrs. mos. ds.

(Signed) A M Ramm M. D.

Mch 16, 1918 (Address) Macon 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

PLACE OF BURIAL OR REMOVAL Bellview Cemetery

DATE OF BURIAL Mar 16 1918

UNDERTAKER Albert Skinner

ADDRESS Macon Mo

PLACE OF DEATH

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

County.....

Township ..... Registration District No..... File No.....

or

Village..... Primary Registration District No..... Registered No.....

or

City .....(NO....., ...St.;.....Ward)

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

FULL NAME.....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

....., *1*.....
(Month) (Day) (Year)

AGE

.....yrs.....mos.....ds.

If LESS than 1 day,.....hrs. or.....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)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant).....

(ADDRESS).....

Filed ....., 191...., ...

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

....., *191*.....
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from ....., 191...., to....., 191...., that I last saw h.....alive on....., 191...., and that death occurred, on the date stated above, at.....m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(Duration).....yrs.....mos.....ds.

Contributory.....
(SECONDARY)

.....(Duration).....yrs.....mos.....ds.

(Signed)..... M. D.

....., 191.... (Address).....

*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.....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	....., 191....
UNDERTAKER	ADDRESS