

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

Do not use this space.

19

**1. PLACE OF DEATH**

County Adair  
Township.....  
City Kirkville (No.....)

Registration District No. 4  
Primary Registration District No. 3001

File No.....  
Registered No. 23  
St..... Ward)

**2. FULL NAME**

(a) Residence. No. Joseph Nicholas Norton St..... Ward.....  
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da. Greensburg Mo  
(If nonresident give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mary E. Norton

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 12-26-1870

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
58 00 29

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Farmer  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

10. NAME OF FATHER Samuel D. Norton

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Ky

12. MAIDEN NAME OF MOTHER Mary J. Timonda

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Indiana

14. INFORMANT Samuel A. Norton (Address) Greensburg Mo

15. FILED 1/25, 1929 C. Backer REGISTRAR  
Deputy

**3 MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 25 Jan 1929

17. I HEREBY CERTIFY, That I attended deceased from 20 Dec, 1928, to 25 Jan, 1929 (that I last saw h..... alive on 24 Jan, 1929, and the death occurred, on the date stated above, at 12:35 a.m.)

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Exhaustion  
137  
136A (duration) yrs. mos. 7 da.  
CONTRIBUTORY Mythical structure (SECONDARY) + Hy percholely prostate (duration) 5 yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED Greensburg  
IF NOT AT PLACE OF DEATH?  
DID AN OPERATION PRECEDE DEATH? yes DATE OF 1-10-29  
WAS THERE AN AMBUSTY? no  
WHAT TEST CONFIRMED DIAGNOSIS? E. J. Smith, M. D.  
(Signed) L. K. Smith  
1/25, 1929 (Address)

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Greensburg DATE OF BURIAL 1-26 1929  
20. UNDERTAKER Dee Riley ADDRESS Kirkville

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.

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