

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

Do not use this space.

25374

1. PLACE OF DEATH

County Oregon
Township Wiley
City (No. _____) _____

Registration District No. 636
Primary Registration District No. 5844

File No. _____
Registered No. 31
St. _____ Ward _____

2. FULL NAME

William Carol Norman

(a) Residence No. _____ St. _____ Ward _____
(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Evelin Norman

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 1 1854

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
74 9 8

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Tennessee
(STATE OR COUNTRY) Tom Norman

10. NAME OF FATHER Tom Norman

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

12. MAIDEN NAME OF MOTHER unknown

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

14. INFORMANT Ada Norman
(Address) Couch MO

15. 8/10/1929 Eunice Bailey REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 9 1929

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, and that I last saw him alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

92A THE CAUSE OF DEATH* WAS AS FOLLOWS:
162 Valves of heart trouble

sterility (duration) yrs. 1 mos. ds. 0
CONTRIBUTORY (SECONDARY) _____ (duration) yrs. 1 mos. ds. 0

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

0 DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) A. B. Forrest, M. D.

, 19 (Address) Alton

*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 Cave Spring DATE OF BURIAL 7/10 1929

20. UNDERTAKER A. S. Carr ADDRESS Alton MO

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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8
1929
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