

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

1510  
1787  
4

Feb 27 1934

1. PLACE OF DEATH  
 County Linn Registration District No. 491 File No. 1510 1787  
 Township Bedford Primary Registration District No. 4298 Registered No. 4  
 City Troy (No. ....) St. .... Ward) .....

2. FULL NAME D. Hasley S. Norton

(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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 22 - 1878

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .... hrs. or .... min.  
55 | 2 | - | or .... min.

8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work M. D.  
 (b) General nature of industry, business, or establishment in which employed (or employer) .....

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

10. NAME OF FATHER Colias Norton

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

12. MAIDEN NAME OF MOTHER Kella Turner

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

14. INFORMANT Ward H. Woodfolk  
 (Address) Troy Mo

15. FILED 1-20 1934 W. P. Smith  
 REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 19 1934

17. I HEREBY CERTIFY, That I attended deceased from Jan 12 1934, to Jan 19 1934, that I last saw him alive on Jan 19 1934, and that death occurred, on the date stated above, at 1:30 P. m.

THE CAUSE OF DEATH, AS FOLLOWS:  
Pneumonia  
 (duration) ..... yrs. .... mos. .... ds.

CONTRIBUTORY (SECONDARY) Myocarditis  
 (duration) ..... yrs. .... mos. .... ds.

18. WHERE WAS DISEASE CONTRACTED  
 IF, NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) J. S. Harris, M. D.  
 , 10 (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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Troy Cemetery DATE OF BURIAL Jan 21 1934

20. UNDERTAKER Kemp Bros ADDRESS Troy Mo

PARENTS

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1 9 1

# 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, Sarcoma, etc., of* \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasm); *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," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "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.)

**NOTE.**—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

WASHINGTON

1785

E. T. McGaugh, M. D.,  
Special Agent,  
Jefferson City, Mo.

*in color*

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Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking on the death certificate.

Name: D. Harley A. Norton  
Died at \_\_\_\_\_ on Jan. 19 - 1934  
Residence: No. \_\_\_\_\_ St. \_\_\_\_\_  
(If nonresident, city or town)

Place of residence in city or town where death occurred: \_\_\_\_\_  
Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_  
Color or race \_\_\_\_\_ Single, married, widowed or divorced: \_\_\_\_\_

Date of birth \_\_\_\_\_ Age: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, weaver, bookkeeper, etc. \_\_\_\_\_  
(b) Industry or business in which work was done, as silk mill, saw mill, bank, etc. \_\_\_\_\_

Deceased last worked at this occupation: Month \_\_\_\_\_ Year \_\_\_\_\_

Place of birth (State or country) \_\_\_\_\_

Place of father (State or country) \_\_\_\_\_

Place of mother (State or country) \_\_\_\_\_

Principal cause of death: Pneumonia Lobar

Other contributory causes of importance Myocarditis

Date of operation \_\_\_\_\_ Date of \_\_\_\_\_

Was test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

Was death due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19 \_\_\_\_\_

Where did injury occur? \_\_\_\_\_

(Specify city or town, county and State)

Whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

If so, specify \_\_\_\_\_

Name of physician \_\_\_\_\_

Address of physician \_\_\_\_\_

Signature of Registrar W. P. Smith Date filed 1-20-34

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Very truly yours,

Reg. Dist. No. 491

Primary Reg. Dist. No. 4298

E. T. McGaugh  
Special Agent, M. D.

S-1787

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