

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1939 OCT 12 1939

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

32526
Do not use this space.

1. PLACE OF DEATH

(a) County Howell Registration District No. 384
 (b) Township..... Primary Registration District No. 4227 Registered No.....
 (c) City West Plains, Mo (d) Street No. Christa Hogan Hospital St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred 8 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

635 Joseph William Norton
 (a) Residence, No. 318 So. Hill, West Plains, Mo. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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) Aug. 27, 1931

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
8 0 5

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) West Plains, Mo.

FATHER 13. NAME J. Edw. Norton

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Oakland, Arkansas

MOTHER 15. MAIDEN NAME Leota Overby

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Pocahontas, Ark.

17. INFORMANT (ADDRESS) J. Edw. Norton, West Plains, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE, DATE Oak Lawn Cem. West Plains, Mo. Sept. 4, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Ha. Thornburgh, West Plains, Mo.

20. FILED 9-4- 1939 Vida N. SIMONS Local Registrar

21. DATE OF DEATH (MONTH, DAY, AND YEAR) September 2, 1939

22. I HEREBY CERTIFY, That I attended deceased from September 1, 1939 to September 2, 1939

I last saw him alive on September 2, 1939 Death is said to have occurred on the date stated above, at 10:45 P.M.

The principal cause of death and related causes of importance were as follows:

General Peritonitis Date of onset

Other contributory causes of importance: Intestinal Obstruction

Name of operation Laparotomy Date of 9/27/39

What test confirmed Specimen Was there an autopsy?

23. If death was 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) Specify whether injury occurred in industry, in home, or in public place.

Manner of injury Nature of injury

24. Was disease or injury in any way related to occupation of deceased? If so, specify

(Signed) Weston, M. D. (Address) West Plains, Mo.

1242

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by

Hal Thornburgh

Registered Apprentice No. ~~340~~

working under my personal supervision.

RECEIVED

District Health Officer No. 5,

District File Number 1089254

Date Filed 10 2 39

Signed

Hal Thornburgh

Licensed Embalmer No. 3408

P. O. Address West Plains

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

32526

Do not use this space.

1. PLACE OF DEATH

(a) County Jowell Registration District No. 384
(b) Township West Plains Primary Registration District No. 4227 Registered No. _____
(c) City West Plains (d) Street No. _____ (If death occurred in Hospital or Institution, write its name instead of street and number) St. _____
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. Joseph William Norton St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED s (Write the word)

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
8 0 5

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER
13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER
15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____, 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED _____, 19

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 2, 1939

22. I HEREBY CERTIFY, That I attended deceased from _____, 1939 to _____, 1939

I last saw h. _____ alive on _____, 1939. Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

General Peritonitis Date of onset _____

Other contributory causes of importance:

Intestinal Obstruction
Caused by abscess
Laparotomy

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was 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)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) R. E. Hogan, M. D.

(Address) West Plains

STATE BOARD OF HEALTH
OFFICE OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

Registered No.

St.
(In U.S., if of foreign birth, give city or town and State)
.....

.....
(Give city or town and State)

OF DEATH

.....

.....
died deceased from

.....

.....
in is said