

JUN 16 1939

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

45012
Do not use this space.

1. PLACE OF DEATH

(a) County Wright Registration District No. 949
(b) Township Union Primary Registration District No. 6225 Registered No. 7
(c) City _____ (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

U-95 Norman H. Helton
(a) Residence, No. _____ 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 White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED ✓
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF ✓
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 25 1935
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
3 11 14

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) Wright Co Mo

FATHER
13. NAME Roy J Helton

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Pulaski Co Mo

MOTHER
15. MAIDEN NAME Nellie Ackman

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Cape Girardeau Mo

17. INFORMANT (ADDRESS) Roy J Helton
Grave Springs Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Wright Co Mo DATE 9/11/39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) W. E. Falman
Grave Springs Mo

20. FILED 12-15-39 C. H. Howell
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9/9/39 1939
22. I HEREBY CERTIFY, That I attended deceased from 9-2 1939, to 9-9 1939
I last saw him alive on 9-9 1939 Death is said to have occurred on the date stated above, at 3:30 P. m.
The principal cause of death and related causes of importance were as follows:

Acute Nephritis
Date of onset _____
Other contributory causes of importance: _____

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? No
If so, specify _____ (Signed) J. W. Lindsey M. D.
_____ (Address) Courway

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

V. S. No. 2.
50M-9-19-38
I X16005

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.

RECEIVED

District Health Officer No. 6,

District File Number 1010-2016

Date Filed JAN 15 1940

126

RECEIVED
DISTRICT HEALTH OFFICER NO. 6

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 myself,
....., Registered Apprentice No.....
working under my personal supervision.

Signed W.E. Holman

Licensed Embalmer No.....

P. O. Address Tabanan Mo

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

450 1207
Do not use this space.

1. PLACE OF DEATH *Wright*

(a) County *Wright* Registration District No. *949*

(b) Township *Wright* Primary Registration District No. *6225* Registered No. *7*

(c) City..... (d) Street No..... 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 *Norwood H. Helton*

(a) Residence, No..... 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 (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. or min.

3 11 14

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

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *9-9 1937*

22. I HEREBY CERTIFY, That I attended deceased from 19... to 19... I last saw him alive on 19... 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:

acute nephritis

Want Know

Other contributory causes of importance: *130*

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) *W. Lindsay*, M. D. (Address) *Conroy*

SUPPLEMENTARY

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PL. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED

S-45012