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

FILED SEP 4 1941

28173
Do not use this space.

1. PLACE OF DEATH
(a) County Dallas — Registration District No. 243
(b) Township Jackson — Primary Registration District No. 5-334 — Registered No.
or
(c) City — (d) Street No. — 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 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: MO
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): M 1
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Tennessee Norton
6. DATE OF BIRTH (MONTH, DAY, AND YEAR): April 18, 1863
7. AGE: YEARS 78 — MONTHS 3 — DAYS 5 — If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.: Farmer
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): Mo, O

FATHER
13. NAME: Unknown
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): "

MOTHER
15. MAIDEN NAME: "
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): "

17. INFORMANT (ADDRESS): Tennessee Norton, Elkland Mo.
18. BURIAL, CREMATION, OR REMOVAL — PLACE: Mt. Olive — DATE: 7-25, 1941
19. FUNERAL DIRECTOR (NAME) (ADDRESS): L. B. Jones, Buffalo Mo.
20. FILED 9-1, 1941 Mrs. J. N. Shewmaker, Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): 7-23, 1941
22. I HEREBY CERTIFY, That I attended deceased from 7-18-, 1941, to 7-23-, 1941
I last saw him alive on 7-18-, 1941. Death is said to have occurred on the date stated above, at 12:45 p.m.
The principal cause of death and related causes of importance were as follows:
Cerebral hemorrhage — Date of onset: 01
83A1
Other contributory causes of importance: High Blood Pressure
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. Harrell, M. D.
(Address) Buffalo, Mo.

(Licensed Embalmer's Statement on Reverse Side)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very impo

RECEIVED
District Health Officer No. 7,
District File Number 9-41-1575
Date Filed 9-3-41

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 .....

....., Registered Apprentice No. .....

working under my personal supervision.

Signed Lloyd Montgomery

Licensed Embalmer No. 3592

P. O. Address Buffalo Mo.

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

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

. No. 2B
—8-21-41
P I X29288

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 28173

Registration District No. 243 Primary Registration District No. 5336 Registrar's No.

1. PLACE OF DEATH:

(a) County Dallas

(b) City or town Jackson
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Dalla

(c) City or town Rural
(If outside city or town limits, write "RURAL")

(d) Street No. Red Top Mo
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Wm A. Norton

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years | Months | Days | If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) 9-1-1941 (Date received local registrar) (b) Mrs I N Shewmaker (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 23
year 1941 hour minute M.

21. I hereby certify that I attended the deceased from
19 to 19
that I last saw h alive on 19
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY