

FILED OCT 17 1946

Registration District No. **75**

Primary Registration District No. **3015**

1. PLACE OF BIRTH:

(a) County **Canton**

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

(c) Name of hospital or institution: **Cogey North Centralizing Home**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **1 week**
(Specify whether years, months or days)

In this community **All his life**

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **Daviess**

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

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Chas R Norton**

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex **Male**

5. Color or race **White**

(a) Single, widowed, married, divorced **Single**

6. (b) Name of husband or wife **Was not married**

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

7. Birth date of deceased **May 12 1876**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
70	4	13	hr. _____ min. _____

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

10. Usual occupation **Retired Farmer**

11. Industry or business _____

12. Name **Stephen Norton**

13. Birthplace **Ky**
(City, town, or county) (State or foreign country)

14. Maiden name **Elizabeth Craig**

15. Birthplace **Ohio**
(City, town, or county) (State or foreign country)

MOTHER FATHER

16. (a) Informant **Mrs Estella Worth**

(b) Address **Butte Montana**

17. (a) **Burial** (Burial, cremation, or removal)

(b) Date thereof **Sep 27 46**
(Month) (Day) (Year)

(c) Place: burial or cremation **Walden**

18. (a) Signature of funeral director **Kate Shoup**

(b) Address **Winstons Mo**

19. (a) **9-30-46** (Date received local registrar)

(b) **Mrs Willie Jones** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sep** day **30**
year **1946** hour **1** minute **0** M.

21. I hereby certify that I attended the deceased from **Sept 20** 19**46** to **Sept 25** 19**46**
that I last saw **him** alive on **Sept 24** 19**46**
and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic Valvular heart disease**

Due to **Generalized arteriosclerosis**

Other conditions (Include pregnancy within 5 months of death) _____

Major findings: Of operations _____

Of autopsy **92D**

Duration _____

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? _____

While at work _____ (Specify type of place)

(c) Means of injury **0**

23. Signature **J. A. Kines** (M. D. or other) _____

Address **Cameron Mo** Date signed **28 Sep 46**

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

DISTRICT HEALTH OFFICE
Cameron, Mo.

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 *L. O. Richman*
Licensed Embalmer No. *3307*
P. O. Address *Fallston 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, fact should be so stated above.