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

28001

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

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.

1. PLACE OF DEATH
County Henry — Registration District No. 350-353 — File No.
Township — Primary Registration District No. 3018 — Registered No. 109
City Clinton (No. St. Ward)

2. FULL NAME Benjamin Houdshell

(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: Cauc
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Widowed

5a. If Married, Widowed, or Divorced HUSBAND of (or) WIFE of: Widowed

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Oct 29 1854

7. AGE: Years 69, Months 10, Days 20. If LESS than 1 day, ...hrs. or ....min.

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

9. BIRTHPLACE (CITY OR TOWN): Winchester
(STATE OR COUNTRY): Virginia

PARENTS

10. NAME OF FATHER: Daniel Houdshell
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Virginia
12. MAIDEN NAME OF MOTHER: Jane Dyer
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Virginia

14. INFORMANT: Misses Houdshell
(Address): Clinton, Mo.

15. FILED 10/3 1924 Ed. C. Chelsea J.C. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Sept 19 1924

17. I HEREBY CERTIFY, That I attended deceased from Sept 14, 1924, to Sept 19, 1924, that I last saw h... alive on Sept 19, 1924, and that death occurred, on the date stated above, at 9 a.m.

THE CAUSE OF DEATH* was as follows:
Apoplexy
(duration) .... yrs. .... mos. 8 ds.

CONTRIBUTORY (SECONDARY): Encephalitis
(duration) 2 yrs. .... mos. .... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? —
DID AN OPERATION PRECEDE DEATH? no DATE OF
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) G. S. Walker, M. D.
Sept 30, 1924 (Address) Clinton Mo.

*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: Englewood — DATE OF BURIAL: 9/21 1924

20. UNDERTAKER: Sims-Wilkinson Co — ADDRESS: Clinton

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CERTIFICATE OF DEATH

1. PLACE OF DEATH

County.................................... Registration District No.................................... File No....................................

Township.................................... Primary Registration District No.................................... Registered No. ....

City.................................... (No.........................., ...St. ....Ward)

2. FULL NAME ....

(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	MEDICAL CERTIFICATE OF DEATH
3. SEX / 4. COLOR OR RACE / 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)	16. DATE OF DEATH (MONTH, DAY AND YEAR) 19
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF	17. I HEREBY CERTIFY, That I attended deceased from ...., 19......., to ...., 19....... that I last saw h.......... alive on ...., 19......., and that death occurred, on the date stated above, at ....m.
6. DATE OF BIRTH (MONTH, DAY AND YEAR)	THE CAUSE OF DEATH* WAS AS FOLLOWS:
7. AGE: YEARS / MONTHS / DAYS / If LESS than 1 day, ...hrs. or ....min.	....
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work	....................(duration)..........yrs. ....mos. ....ds.
(b) General nature of industry, business, or establishment in which employed (or employer)....................	CONTRIBUTORY (SECONDARY) ....(duration)..........yrs. ....mos. ....ds.
(c) Name of employer	18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH?....................
9. BIRTHPLACE (CITY OR TOWN) .... (STATE OR COUNTRY)	DID AN OPERATION PRECEDE DEATH?.......... DATE OF....................
PARENTS — 10. NAME OF FATHER	WAS THERE AN AUTOPSY?....................
11. BIRTHPLACE OF FATHER (CITY OR TOWN).................... (STATE OR COUNTRY)	WHAT TEST CONFIRMED DIAGNOSIS?....................
12. MAIDEN NAME OF MOTHER	(Signed)...................., M. D. , 19 (Address)
13. BIRTHPLACE OF MOTHER (CITY OR TOWN).................... (STATE OR COUNTRY)	*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.)
14. INFORMANT .... (Address)	19. PLACE OF BURIAL, CREMATION, OR REMOVAL / DATE OF BURIAL 19
15. FILED.........., 19........ .... REGISTRAR	20. UNDERTAKER / ADDRESS