

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.

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

Do not use this space.

14536

1. PLACE OF DEATH
 County.....
 Township.....
 City..... (No. *Deaconess Hospital*)
 Registration District No. **791**
 Primary Registration District No. **1003**
 File No.
 Registered No. **3884**
 St. Ward)

2. FULL NAME *Herbert C Houck*
 (a) Residence. No. *6023 Emigler* St. *5* 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 *white*
5. SINGLE, MARRIED, WIDOWED OR DIVORCED *married*
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Marian E Houck*
6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Jan 7 1885*
7. AGE YEARS MONTHS DAYS If LESS than 1 day,hra. ormin.
45 3 10
8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work..... *Food Broker*
 (b) General nature of industry, business, or establishment in which employed (or employer).....
 (c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Mo.*
10. NAME OF FATHER *Fred C Houck*
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *Mo.*
12. MAIDEN NAME OF MOTHER *Paulina Rhea*
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) *Mo.*

14. INFORMANT *Mrs Margu E Houck*
 (Address) *6023 Emigler*

15. FILED 19 *1930*
Max C Storker REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *April 17 1930*
17. I HEREBY CERTIFY That I attended deceased from *Mo* *29* 19*30* to *April 17* 19*30* that I last saw him alive on *April 16* 19*30* and that death occurred, on the date stated above, at *2:30* m.

THE CAUSE OF DEATH WAS AS FOLLOWS: *2 A. Chronic Toxicity and Nephritis*
131 (duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) *1240* (duration) yrs. mos. ds.
18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH.....
8 DID AN OPERATION PRECEDE DEATH?..... DATE OF.....
 WAS THERE AN AUTOPSY?.....
 WHAT TEST CONFIRMED DIAGNOSIS?.....
 (Signed) *[Signature]* M. D.
4/18/30 (Address) *616 Westport St*

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *Mr. Lebanon* *Law*
DATE OF BURIAL *4/19 1930*
20. UNDERTAKER *A. G. S. 5240 Delmar*
ADDRESS *5240 Delmar*

