

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.

DEC 20 1937

40322

1. PLACE OF DEATH

County Jackson  
Township North  
City Mauas city (No. St. Maure Neaps)

Registration District No. 399  
Primary Registration District No. 1002

File No. \_\_\_\_\_  
Registered No. 4636  
St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME

Constance Lucille Huston

(a) Residence, No. 3239 St John 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 Fe 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct-20-1937

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
0 0 26

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. \_\_\_\_\_  
9. Industry or business in which work was done, as silk mill, 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) Mauas city

13. NAME Royal M Huston

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ill

15. MAIDEN NAME Celina Young

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mauas city Mo.

17. INFORMANT Royal M Huston  
(ADDRESS) 13239 St John

18. BURIAL, CREMATION, OR REMOVAL  
PLACE Green Lawn DATE Nov. 17-1937

19. UNDERTAKER Miss C R Foster  
(ADDRESS) 918 Broadway

20. FILED Nov 17, 1937 M. M. Brown  
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov. 16, 1937

22. I HEREBY CERTIFY, That I attended deceased from Oct. 20, 1937, to Nov. 16, 1937.  
I last saw him alive on Nov. 16, 1937. Death is said to have occurred on the date stated above, at 6:30 p.m.

The principal cause of death and related causes of importance were as follows:

Cerebral encephalocoele Date of onset \_\_\_\_\_

Acute suppurative meningitis (hem. epidemic)

Other contributory causes of importance:

157 lb W

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis Autopsy Was there an autopsy Yes

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 of injury in any way related to occupation of deceased? \_\_\_\_\_  
If so, specify \_\_\_\_\_  
(Signed) A. H. Clark, M. D.  
(Address) 1109 Prof Bldg

205 - Prof. Bell -

Ve 41120

Medical Cert Bell -  
with Veteran Reimburse

Pa - 4261 -