

OCT 20 1938

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

32261
Do not use this space.

1. PLACE OF DEATH

(a) County Greene
(b) Township Campbell
(c) City Springfield
(e) Length of residence in city or town where death occurred 0 yrs. 2 mos. 1 ds.

Registration District No. 318
Primary Registration District No. 5449 Registered No. 692
(d) Street No. U.S. Federal Hospital St. U.S. Federal Hospital
(If death occurred in Hospital or Institution, write its name instead of street and number)
(f) How long in U.S., if of foreign birth? - yrs. - mos. - ds.

2. PRINT FULL NAME HUSTON, Don

(a) Residence, No. _____ St. Chicago, Ill.
(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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mrs. Louise Huston

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar. 24, 1887

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
51 5 12

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Salesman

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) D.K. 11. Total time (years) spent in this occupation D.K.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Custeen, Iowa

13. NAME David Houston

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) D. K.

15. MAIDEN NAME Lillie Houston

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) D. K.

17. INFORMANT Deceased
(ADDRESS)

18. BURIAL, CREMATION OR REMOVAL PLACE Springfield, Mo. DATE 9-8-38

19. FUNERAL DIRECTOR (NAME) Alma Lohmeyer Fun. Home
(ADDRESS) Springfield, Mo.

20. FILED Sept 6 1938 Chas. A. Berger Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept. 6, 1938

22. I HEREBY CERTIFY, That I attended deceased from July 5, 1938, 19____, to Sept. 6, 1938, 19____.

I last saw him alive on Sept. 6, 1938, 19____. Death is said

to have occurred on the date stated above, at 8:40 P.M.

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

Tuberculosis, pulmonary, chronic

Date of onset 1906

Other contributory causes of importance:

None

Name of operation None Date of _____

What test confirmed diagnosis? Clinical 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 or injury in any way related to occupation of deceased? No

If so, specify SURGERY

(Signed) E. W. Green, P. A. Surgeon, M. D.

(Address) Clinical Director, USHDD

Springfield, Mo.

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.

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.....

Licensed Embalmer No.....

P. O. Address.....

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, above space should be left blank.