

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

2403
Do not use this space.

FEB 13 1940

1. PLACE OF DEATH
(a) County GREENE Registration District No. 315
(b) Township SPRINGFIELD Primary Registration District No. 2001 Registered No. 72
(c) City SPRINGFIELD (d) Street No. 1403 N. Clay St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME JOP THOMAS MARION HOUGH

(a) Residence, No. 1403 N. Clay St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Clara Davis

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) aug 5 - 1877

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. 62 5 17

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Laborer
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)
11. Total time (years) spent in this occupation.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Maintain Grove Mo

FATHER
13. NAME Paton Hough
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

MOTHER
15. MAIDEN NAME Nancy A. Wilson
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

17. INFORMANT Mrs. Elsie Hough (ADDRESS) 1403 N. Clay

18. BURIAL, CREMATION, OR REMOVAL PLACE Green Lawn DATE 1-25 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Dunn Springfield Mo

20. FILED 1-25 1940 Chas. R. George M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 29 1940

22. I HEREBY CERTIFY, That I attended deceased from Jan 21st 1940 to Jan 23rd 1940
I last saw him alive on Jan 23rd 1940 Death is said to have occurred on the date stated above, at 12:30 P.M.
The principal cause of death and related causes of importance were as follows:
Chr. Valvular Heart Disease Date of onset 92 W
Other contributory causes of importance Cardic Asthma
Name of operation none Date of
What test confirmed diagnosis? P Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? No 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

(Signed) J. E. Payle M. D. (Address) Springfield, Missouri

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.....

Floyd W. Fox

Licensed Embalmer No. *2910*

P. O. Address *629 W. Walnut*

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.

X