

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.

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

43285
Do not use this space.

JAN 21 1941

PLACE OF DEATH

(a) County Miller Registration District No. 597
(b) Township North Primary Registration District No. 3792 Registered No.
(c) City (d) Street No. 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 3 yrs. mo. da. (f) How long in U. S., if of foreign birth? yrs. mo. da.

2. PRINT FULL NAME MARCO BELL O HOUSTON
(a) Residence, No. MILLER CO. St. ELDON, MO.
(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 F 4. COLOR OR RACE NMER 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) WIDOWED
5A. IF MARRIED, WIDOWED, OR DIVORCED (OR) WIFE OF COLLIER HOUSTON
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 12-3-1874
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
66 8 25
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc. housewife
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) Miller Co Mo
13. NAME STEVEN HOWARD
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) N. Y.
15. MAIDEN NAME HANNAH FARRIS
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)
17. INFORMANT Mrs Johna Maelle (ADDRESS)
18. BURIAL, CREMATION, OR REMOVAL PLACE Salem DATE 12-12-1940
19. FUNERAL DIRECTOR (NAME) (ADDRESS) Carl Young
20. FILED 110 1941 H. C. Callahan Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12-10-1940
22. I HEREBY CERTIFY, That I attended deceased from Monday 1938 to dec 10 1940
I last saw him alive on dec 10 1940 Death is said to have occurred on the date stated above, at 11:40 AM
The principal cause of death and related causes of importance were as follows:
appt. cerebral Hemorrhage Date of onset 1915
Other contributory causes of importance: Heart Disease 1938
Name of operation none Date of
What test confirmed diagnosis? Was there an autopsy? no
23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury
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) A. F. Burkholder M. D. (Address) Eldon Mo

529 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 7,

District File Number 1-41-100

Date Filed 1-13-41

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.

Registration District No. 597

Primary Registration District No. 5792

Registrar's No. _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Morgan
(b) City or town Morgan T.P.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
in this community _____
years, months or days)

3. (a) PRINT FULL NAME Margaret Bell Houston
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex 7 (5. Color or race white) 6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ year _____

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
66 8 25 hr. min.

9. Birthplace Miller Co. Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 12/11-41 (b) H. E. Callison
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH Month 12 day 10
year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that last saw h _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration

Due to _____

Due to _____

Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature G. J. Berkstresser (M.D. or other)

Address Edon Mo Date signed _____

SUPPLEMENTAL

S-43285