

FILED JUL 14 1998

MISSOURI DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

STATE FILE NUMBER

124 - 40-044256

REGISTRATION DISTRICT NO. 119 REGISTRAR'S NUMBER DELAYED 235004

1. DECEDENT'S NAME (First, Middle, Last) Emma Roberson Houston
 2. SEX female
 3. DATE OF DEATH (Month, Day, Year) November 20, 1940
 4. SOCIAL SECURITY NO.
 5a. AGE - Last Birthday (Years) 68
 5b. UNDER 1 YEAR MONTHS DAYS
 5c. UNDER 1 DAY HOURS MINUTES
 6. DATE OF BIRTH (Month, Day, Year) July 9, 1872
 7. BIRTHPLACE (City and State or Foreign Country) Maries County, Missouri

8. WAS DECEDENT EVER IN U.S. ARMED FORCES?
 Yes No Unk.
 9a. PLACE OF DEATH (Check only one; see instructions on other side)
 HOSPITAL: Inpatient ER/Outpatient DOA
 OTHER: Nursing Home Residence Other (Specify)

9b. FACILITY NAME (If not institution, give street and number)
 9c. CITY, TOWN, OR LOCATION OF DEATH Southwest City
 9d. COUNTY OF DEATH McDonald

10. MARITAL STATUS - Married, Never Married, Widowed, Divorced, (Specify) Married
 11. SURVIVING SPOUSE'S NAME (If wife, give full maiden name) J. A. Houston
 12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.) Housewife
 12b. KIND OF BUSINESS OR INDUSTRY Own Home

13a. RESIDENCE - STATE Missouri
 13b. COUNTY McDonald
 13c. CITY, TOWN, OR LOCATION Southwest City
 13d. ZIP CODE 64863

13e. STREET AND NUMBER
 13f. INSIDE CITY LIMITS Yes No
 13g. YEARS AT PRESENT ADDRESS Under 5 5-9 10-19 20 or more

14. WAS DECEDENT OF HISPANIC ORIGIN (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.)
 No Yes Specify:
 15. RACE - American Indian, Black, White, etc. (Specify) White
 16. DECEDENT'S EDUCATION (Specify only highest grade completed)
 Elementary/Secondary (0-12) College (1+ or 5+)

17. FATHER'S NAME (First, Middle, Last) Rich nmn Roberson
 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary E. Crawford

19a. INFORMANT'S NAME (Type/Print) J. A. Houston
 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Southwest City, Missouri 64863

20a. BURIAL, CREMATION, OTHER (Specify) Burial
 20b. DATE OF DISPOSITION (Month, Day, Year) November 21, 1940
 20c. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) Lee Cemetery
 20d. LOCATION - City or Town, State Benton County, Arkansas

21. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH
 22a. NAME AND ADDRESS OF FACILITY Nichols Brothers, Southwest City, Missouri
 22b. FUNERAL ESTABLISHMENT LICENSE NUMBER

23. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
 IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Apoplexy
 DUE TO (OR AS A CONSEQUENCE OF):
 b. Hypertension, Myocarditis, Senility
 DUE TO (OR AS A CONSEQUENCE OF):
 c.
 DUE TO (OR AS A CONSEQUENCE OF):
 d.
 Approximately Interval Between Onset and Death

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
 24. IF DECEASED WAS FEMALE 10-49, WAS SHE PREGNANT IN THE LAST 90 DAYS? Yes No Unk.
 25a. WAS AN AUTOPSY PERFORMED? Yes No
 25b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? Yes No

26. MANNER OF DEATH Natural Pending Investigation Accident Suicide Could not be Determined Homicide
 27a. DATE OF INJURY (Month, Day, Year)
 27b. TIME OF INJURY M
 27c. WAS INJURY ALCOHOL-RELATED? (Not limited to decedent.) Yes No Unk.
 27d. INJURY AT WORK? Yes No Unk.
 27e. DESCRIBE HOW INJURY OCCURRED
 27f. PLACE OF INJURY - At home, farm street, factory, office building, etc. (specify)
 27g. LOCATION (Street and Number or Rural Route Number, City or Town, State)

28a. (Specify) CERTIFYING PHYSICIAN MEDICAL EXAMINER/CORONER
 28b. To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) stated. (Signature and Title)
 28c. DATE SIGNED (Month, Day, Year)
 28d. TIME OF DEATH M

29a. NAME AND ADDRESS OF CERTIFIER (PHYSICIAN, MEDICAL EXAMINER OR CORONER) (Type or Print) Dr. R. E. Warmack, M.D. Southwest City, Missouri
 29b. MO. LICENSE NUMBER
 30. WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? Yes No

31. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER
 32. REGISTRAR'S SIGNATURE Garland H. Land
 33. DATE RECEIVED BY LOCAL REGISTRAR (Month, Day, Year) July 14, 1998

notarized statement of a Home, and Funeral Home, Died Nov. 20, 1940
 of a Home, and Funeral Home, record and cemetery
 Filed on the basis from the Ozark Fun record and cemetery

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

DO NOT WRITE ON THIS STUB

7-cy	12a	23u	27g-co
9a	13e	23-sc1	29g-cy
9b	13b	27-sc2	29a
9c	14	27e-f	29b
12b	15	27g-st	

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 _____, Student Embalmer No. _____ working under my personal supervision.

Student _____ Signed _____
 Signature of Student Embalmer Licensed Embalmer No. _____

NAME OF DECEDENT _____ 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting. If this body is not embalmed, fact should be so stated above.

INSTRUCTIONS FOR SELECTED ITEMS

Item 9a - Place of Death

If the death was pronounced in a hospital, check the box indicating the decedent's status at the institution (inpatient, emergency room/outpatient, or dead on arrival (DOA)). If death was pronounced elsewhere, check the box indicating whether pronouncement occurred at a nursing home, residence, or other location. If other is checked, specify where death was legally pronounced, such as a physician's office, the place where the accident occurred, or at work.

Item 13a-g - Residence of Decedent

Residence of the decedent is the place where he or she actually resided. This is not necessarily the same as "home state," or "legal residence." Never enter a temporary residence such as one used during a visit, business trip, or a vacation. Place of residence during a tour of military duty or during attendance at college is not considered as temporary and should be considered as the place of residence. If a decedent had been living in a facility where an individual usually resides for a long period of time, such as a group home, mental institution, nursing home, penitentiary, or hospital for the chronically ill, report the location of that facility in items 13a through 13g. If the decedent was an infant who never resided at home, the place of residence is that of the parent(s) or legal guardian. Do not use an acute care hospital's location as the place of residence for any infant.

Item 23 - Cause of Death

The cause of death means the disease, abnormality, injury or poisoning that caused the death, not the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. In Part I the immediate cause of death is reported on line (a). Antecedent conditions, if any, which gave rise to the cause are reported on lines (b), (c), and (d). The underlying cause should be reported on the last line used in Part I. No entry is necessary on lines (b), (c), and (d) if the immediate cause of death on line (a) describes completely the chain of events. ONLY ONE CAUSE SHOULD BE ENTERED ON A LINE. Additional lines may be added if necessary. Provide the best estimate of the interval between the onset of each condition and death. Do not leave the interval blank; if unknown, so specify. In Part II, enter other important diseases or conditions that may have contributed to death but did not result in the underlying cause of death given in Part I.

EXAMPLE OF
PHYSICIAN
CERTIFICATION:

23. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					Approximate Interval Between Onset and Death
IMMEDIATE CAUSE → <i>(Final disease or condition resulting in death)</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (disease or injury that initiated events resulting in death) LAST	a.	Rupture of myocardium			Mins
	DUE TO (OR AS A CONSEQUENCE OF):				
	b.	Acute myocardial infarction			6 days
	DUE TO (OR AS A CONSEQUENCE OF):				
c.	Chronic ischemic heart disease			5 years	
DUE TO (OR AS A CONSEQUENCE OF):					
d.					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
Diabetes, Chronic obstructive pulmonary disease, smoking					
24. IF DECEASED WAS FEMALE 10-49, WAS SHE PREGNANT IN THE LAST 90 DAYS?		25a. WAS AN AUTOPSY PERFORMED?		25 b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
26. MANNER OF DEATH	27a. DATE OF INJURY (Month, Day, Year)	27b. TIME OF INJURY	27c. WAS INJURY ALCOHOL-RELATED? (Not related to decedent)	27d. INJURY AT WORK?	27e. DESCRIBE HOW INJURY OCCURRED
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide		M.	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNK.	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNK.	
27f. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)			27g. LOCATION (Street and Number or Rural Route Number, City or Town, State)		

EXAMPLE OF
MEDICAL
EXAMINER OR
CORONER

23. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					Approximate Interval Between Onset and Death
IMMEDIATE CAUSE → <i>(Final disease or condition resulting in death)</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (disease or injury that initiated events resulting in death) LAST	a.	Cerebral laceration			10 mins.
	DUE TO (OR AS A CONSEQUENCE OF):				
	b.	Open skull fracture			10 mins.
	DUE TO (OR AS A CONSEQUENCE OF):				
c.	Automobile accident			10 mins.	
DUE TO (OR AS A CONSEQUENCE OF):					
d.					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
24. IF DECEASED WAS FEMALE 10-49, WAS SHE PREGNANT IN THE LAST 90 DAYS?		25a. WAS AN AUTOPSY PERFORMED?		25 b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unk.		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
26. MANNER OF DEATH	27a. DATE OF INJURY (Month, Day, Year)	27b. TIME OF INJURY	27c. WAS INJURY ALCOHOL-RELATED? (Not related to decedent)	27d. INJURY AT WORK?	27e. DESCRIBE HOW INJURY OCCURRED
<input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide	11/15/85	1 p.M.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unk.	2-car collision-driver
27f. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)			27g. LOCATION (Street and Number or Rural Route Number, City or Town, State)		
Street			Route 4, Jefferson City, Missouri		